2018 Employee Benefits Guide

Small Town Service, Community Stewardship, Future Focus

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*This Benefits Guide is informational only, and may not supersede the Town's Memoranda of Understanding, Compensation and **Benefit Plans, and/or group benefit plan documents**.*

Town of Los Gatos

Mission

The Mission of the Town of Los Gatos is to enhance the quality of life in Los Gatos by providing the highest quality leadership and most efficient services and facilities. The Town strives to provide a working environment which promotes excellence; fosters cooperation; values volunteerism; and seeks to meet the needs of the community and the Town Council, employees, Commissions, Committees and Boards.

Customer Service Commitment

All Town employees consistently go the extra step to deliver highly competent and professional services in a respectful, effective, and transparent manner. We engage in open communication, relationship building, and problem solving to provide the best service possible.

Organizational Values

We are committed to serving the COMMUNITY of Los Gatos

- Small Town service – responsive, timely, courteous
- Cost-effective, quality services
- Seamless service delivery
- Public service orientation

We are committed to working together in COLLABORATION

- Open and constructive communication
- Collective goals and shared purposes

We are committed to valuing and pursuing CREATIVITY

- Innovation and creative problem solving
- Future orientation and proactive efforts
- Organization learning and continuous improvement
- Positive and enjoyable work environment

We are committed to approaching our work and each other with impeccable CHARACTER

- Ethics and integrity
- Honesty
- Trust and respect for one another
- Pride in work

A message from Town Manager, Laurel Prevetti

2018 Benefits Plan Year

Have questions?

Contact Human Resources:

Email: hr@losgatosca.gov

Telephone: (408) 399-5739

This benefits booklet is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your insurance company's Evidence of Coverage. The Evidence of Coverage is the binding document between the health plan and its members. If there are any discrepancies between the benefits in this booklet and the Evidence of Coverage, the Evidence of Coverage will prevail. You may also contact your insurance carrier with questions.

At the Town of Los Gatos, we recognize that the delivery of high quality services depends on our talented and dedicated workforce. We appreciate the contributions of each and every employee to make Los Gatos a special place. Thank you all!

Through our benefits programs, we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access, and affordable for all of our employees. Our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees for the Town. This brochure will help you choose the type of plan and level of coverage that is right for you.

Thank you for all you do every day and I am pleased to be able to offer you a range of employee benefits as part of your overall remuneration package.

Yours sincerely,

Laurel Prevetti

Town Manager
lprevetti@losgatosca.gov

2018 Benefits Highlights

These next two pages provide a high level overview of the benefits available to you as a Town employee. Some are Town paid and some are voluntary, should you choose to participate.

Medical

Choosing the right health plan is probably one of the most important decisions you can make for you and your family. It is our objective to provide an employee benefit program with a high level of benefits making it easy for you and your dependents to access the medical care you need. Please carefully consider the plan information provided in this document to make the best medical choice for you and your family. Always remember to eat right and get plenty of exercise to feel your best!

The medical plans include prescription drug coverage. Generic drugs have the same active chemical ingredients and therapeutic effect as their brand-name equivalents, and are the least expensive. The Town pays for 100% of the Kaiser plan for employee only coverage and 90% for dependent coverage.

Dental

Our dental plan makes dental care more affordable for employees and their families. Remember to choose a dentist contracted with our plan for the biggest dental benefit. Taking care of your mouth, teeth, and gums is a big part of making sure you feel your best. Healthy habits like brushing, flossing, and seeing your dentist for regular cleanings help prevent problems. The Town pays for the premiums for select dental plans.

Vision

Eye doctors detect problems in vision, overall eye health, and other health conditions like diabetic eye disease, high blood pressure, and high cholesterol. We know your eyesight is precious to you, so we provide vision benefits to make sure your trip to the eye doctor is reasonably priced. The Town pays for the premiums for vision (employee only).

Life and AD&D

Life and Accidental Death & Dismemberment (AD&D) protects employees and their families from financial hardship in the event of death. It provides the peace of mind you get when you know your loved ones will be protected if anything happens to you. The Town provides employees with a $50,000 policy. Employees may purchase additional insurance coverage for themselves and their eligible dependents.

2018 Benefits Highlights *continued*

Disability

One of the most important assets to you as an employee is the ability to earn an income. The disability program is designed to continue providing you with income if you are unable to work due to sickness or injury. Disability insurance can help you continue to pay your bills by replacing a portion of your income until you are able to return to work. Short Term Disability premiums are paid by the Town. The benefit is 60% of weekly salary (max of $1,300). Long Term Disability premiums are also paid by the Town. The benefit is 60% of monthly salary (max of $6,000).

Employee Assistance Program

The Employee Assistance Plan (EAP) is an employer-paid benefit providing resources for everyday living. Employee assistance professionals provide counseling and referral for continued therapy or treatment services anytime you or a family member are seeking to maintain mental and emotional well-being. The EAP can assist with a variety of life's issues.

Flexible Spending Accounts

If you elect to participate in the Flexible Spending Accounts, you can set aside pre-tax dollars each year to cover your eligible out-of-pocket health-related expenses and/or daycare expenses.

Voluntary Plans

The Town also offers optional insurance plans including Term Life Insurance, Accident, Cancer, and Critical Illness coverage.

457 Deferred Compensation Plan

The Town offers an employee-funded 457 Deferred Compensation Plan to help employees build a path to financial wellness for retirement.

Retirement Benefits

For sworn (Safety) employees: CalPERS enrollment in either 3% at 50 benefit formula for Classic members or 2.7% at 57 benefit formula for New Members (PEPRA) dependent on the individual's eligibility.

For non-sworn (Miscellaneous) employees: CalPERS enrollment in either 2% at 60 benefit formula for Classic Members or 2% at 62 benefit formula for New Members (PEPRA) dependent on the individual's eligibility.

Tuition Reimbursement

$1,500 per fiscal year for non-sworn employees; up to the cost of two semesters at San Jose State University per fiscal year for sworn employees.

Enrollment and Eligibility

If you decide to enroll in benefit coverage, whether it is during your initial eligibility as a new hire or during open enrollment, you must complete the enrollment process.

Eligibility

Who is eligible for benefits?

All regular Town of Los Gatos employees working at least 20 hours per week and more than 1,000 hours in a fiscal year may be eligible for benefits. If you are enrolling as a new employee, your medical, dental, and vision benefits are active as of the first of the month following the month in which you were hired, and your disability plan and life insurance is effective as of your date of hire. You may also choose to enroll your eligible dependents in many of our benefits. Contact the Human Resources department for specific plan details.

Enrollment and Qualifying Events

Each year you have the opportunity to make changes to your benefits package during open enrollment. With the exception of certain qualifying events, open enrollment is the only time benefit changes may be made. A qualifying event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some qualifying events include: a change in legal marital status, change in number of dependents, change in employment status for you or your spouse, birth or adoption of a child. If such a change occurs, you must make the changes to your benefits within 30 days of the qualifying event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the qualifying event may result in your having to wait until the next open enrollment period to make your change. This includes the enrollment of a newborn child. Please contact Human Resources to make these changes.

Choosing a Medical Plan

Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) plan provides health care from specific doctors and hospitals under contract with the plan, and you must select a Primary Care Physician (PCP) to coordinate your care. This type of plan has no deductible, and co-payments are due for services. Please note that the Anthem Select HMO plan has a smaller network of doctors.

Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) plan allows you to obtain medical care from any provider, but you will receive a higher level of benefit and will have less out-of-pocket costs if you see a provider or go to a facility that is part of the network. This type of plan has an annual deductible that must be met first before most benefits apply. Please note that the PERS Select PPO has a smaller network of doctors.

Why would I choose a PPO Plan?

- You have a doctor that you like that you would like to keep seeing.
- You want to see specialists and other providers without having to obtain a referral and/or pre-approval first.
- You want the freedom to see providers who are not in the network.
- You are confident that you can manage your own care.

Why would I NOT choose a PPO Plan?

- You do not want the extra responsibility of managing your own care.
- You do not want to pay the higher premium costs and/or out-of-pocket costs when obtaining care.
- You do not want to receive bills from providers.

Contributions

Health Care Benefits

The Town provides a generous employer contribution toward the purchase of medical, dental, and vision coverage. When choosing your health plan, please note that the Town aligns its contribution rates with the CalPERS Kaiser Bay Area premium. The Town's Contribution Rates for 2018 plan year are as follows:

Level of Participation	Medical	Dental	Vision
Employee Only	$779.86	Up to $ 124.80	$10.64
Employee & 1 Dependent	$1,481.74	Up to $ 124.80	$10.64
Employee & 2+ Dependents	$1,902.86	Up to $ 124.80	$10.64

**Contribution Rates will be pro-rated based on part-time status for eligible employees.*

Cost of Coverage

Plan	Premiums			Employee's Monthly Out-of-Pocket Cost		
	Employee Only	Employee & 1 Dependent	Employee & 2+ Dependents	Employee Only	Employee & 1 Dependent	Employee & 2+ Dependents
Medical						
Kaiser (HMO)	$779.86	$1,559.72	$2,027.64	$0	$77.98	$124.78
Anthem Select (HMO)	$856.41	$1,712.82	$2,226.67	$76.56	$231.08	$323.82
Anthem Traditional (HMO)	$925.47	$1,850.94	$2,406.22	$145.62	$369.20	$503.36
Blue Shield Access+ (HMO)	$889.02	$1,778.04	$2,311.45	$109.16	$296.30	$408.60
Health Net SmartCare (HMO)	$863.48	$1,726.96	$2,245.05	$83.62	$245.22	$342.20
United Healthcare (HMO)	$1,371.84	$2,743.68	$3,566.78	$591.98	$1,261.94	$1,663.92
Western Health Advantage (HMO)	$792.56	$1,585.12	$2,060.66	$12.70	$103.38	$157.80
PERSCare (PPO)	$882.45	$1,764.90	$2,294.37	$102.58	$283.16	$391.50
PERS Choice (PPO)	$800.27	$1,600.54	$2,080.70	$20.40	$118.80	$177.84
PERS Select (PPO)	$717.50	$1,435.00	$1865.50	$0	$0	$0
PORAC (PPO) *	$734.00	$1,540.00	$1,970.00	$0	$58.26	$67.14
Dental						
DeltaCare USA (HMO)	$44.66	$44.66	$44.66	$0	$0	$0
Delta PPO (Fee for Service)	$139.80	$139.80	$139.80	$15	$15	$15
Vision						
Vision Service Plan	$10.64	$15.25	$27.44	$0	$4.61	$16.80

** Available to Public Safety/Sworn Employees only.*

- *Medical rates shown are based on the CalPERS 2018 Bay Area Region.*
- *Not all HMO plans are available in all California counties. To check if these plans are available in your zip code, please visit the CalPERS website at https://www.calpers.ca.gov/ghlt/zipsearch/memHealthPlanSearch.htm.*
- *Enrollment can be based on residential or work zip code*

Contributions *continued*

Retiree Medical Benefit

The Town provides a substantial contribution toward the purchase of CalPERS medical insurance for employees who retire from the Town on or after age 50. Contribution toward retiree medical increases based on eligible dependents covered on the retiree's medical plan. The Town's Share for Retiree Medical Insurance for the 2018 plan year are as follows:

Level of Participation	Non-Medicare	Medicare Eligible
Employee Only	$779.86	$316.34
Employee & 1 Dependent	$1,443.45	$601.05
Employee & 2+ Dependents	$1,547.16	$885.75

Cash Allocation Plan (In Lieu of Medical Coverage)

Employees who have minimum essential medical coverage through other sources may elect to waive enrollment in the Town's medical plan. Those satisfying the Town's requirements may be eligible for a monthly cash allocation payment amount. The employee must provide proof of other coverage in order to participate and proof of other coverage must be provided every plan year. The cash allocation amounts are as follows:

Association Group	Monthly Amount
AFSCME	$420.00
Confidential	$800.00
Confidential (hired after 11/15/04)	$400.00
Management	$950.00
Management (hired after 11/15/04)	$400.00
Police Officers' Association (POA)	$922.00
Police Officers' Association (hired after 1/1/06)	$400.00
Town Employee Association (TEA)	$800.00
Town Employee Association (hired after 11/15/04)	$400.00

Cigna Life Insurance

Basic Life and AD&D Insurance is provided by the Town at no cost to eligible employees. The monthly cost for Supplemental Life Insurance is calculated based on the age and the amount of insurance you purchased for yourself and/or your spouse at the start of the plan's current policy year.

Retirement Benefits

The Town contracts with the Public Employees' Retirement System (PERS) to provide a defined pension benefit to eligible employees in the Safety and Miscellaneous groups in accordance with the California Public Employees' Pension Reform Act of 2012 (PEPRA). The benefits are as follows:

Safety – Tier 1 – Classic	
Employees hired with reciprocity or CalPERS membership prior to 1/1/13 without a break in service of six months or more.	
Retirement Formula	3% at 50
Final Average Compensation Period	1 Year
Employee Contribution	9%
Earliest Age of Retirement	50
Credit for Unused Sick Leave	Yes
1959 Survivor Benefits	Level 4 - $500. Employee contributes $.93 bi-weekly.

Safety – Tier 2 – PEPRA	
Employees hired on or after 1/1/13 who are new members of the CalPERS system or had a lapse of service in the system for six months or more.	
Retirement Formula	2.7% at 57
Final Average Compensation Period	3 Years
Employee Contribution	12.25%
Earliest Age of Retirement	50
Credit for Unused Sick Leave	Yes
1959 Survivor Benefits	Level 4 - $500. Employee contributes $.93 bi-weekly.

Miscellaneous – Tier 1 – Classic	
Employees hired and enrolled in CalPERS membership prior to 9/15/12.	
Retirement Formula	2.5% at 55
Final Average Compensation Period	1 Year
Employee Contribution	8%
Earliest Age of Retirement	50
Credit for Unused Sick Leave	No
1959 Survivor Benefits	Level 4 - $500. Employee contributes $.93 bi-weekly.

Miscellaneous – Tier 2 – Classic	
Employees hired on or after 9/15/12 with reciprocity or members of the CalPERS system prior to 1/1/13 without a break in service of six months or more.	
Retirement Formula	2% at 60
Final Average Compensation Period	3 Years
Employee Contribution	7%
Earliest Age of Retirement	50
Credit for Unused Sick Leave	No
1959 Survivor Benefits	Level 4 - $500. Employee contributes $.93 bi-weekly.

Retirement Benefits *continued*

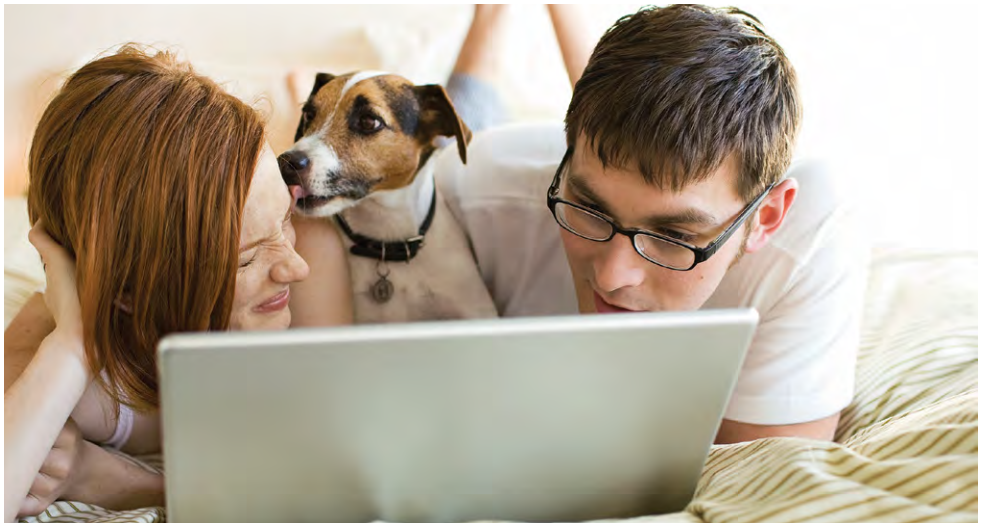
Miscellaneous – Tier 3 - PEPRA	
Employees hired on or after 1/1/13 who are new members of the CalPERS system or had a lapse of service in the system for six months or more.	
Retirement Formula	2% at 62
Final Average Compensation Period	3 Years
Employee Contribution	6.75%
Earliest Age of Retirement	50
Credit for Unused Sick Leave	No
1959 Survivor Benefits	Level 4 - $500. Employee contributes $.93 bi-weekly.

Council Members

Council Members are included in PERS classification of "Optional Membership". They may opt out of PERS membership for retirement when appointed, but may choose to enroll at any time in the future. They can enroll in a PERS health plan even if they elect to waive PERS membership. Council Members who enroll in PERS retirement will receive benefits at the appropriate Tier 1 Classic, Tier 2 Classic, or Tier 3 PEPRA, depending on the date of appointment to the Town Council.

Social Security and Medicare

The Town does not participate in Social Security, except for the required Medicare rate of 1.45% of all wages. Town employees contribute the applicable percentage of all wages toward Medicare. Rates and earnings limits are set by federal law.



Explore
Learn
Decide

my.calpers.ca.gov

CalPERS Health Open Enrollment 2017

Starts September 11 and ends October 6

2018 Health Program Highlights

CalPERS is offering seven Health Maintenance Organization (HMO) and three Preferred Provider Organization (PPO) options for Basic (non-Medicare) subscribers, including Anthem Blue Cross, Blue Shield of California, Health Net, Kaiser Permanente, Sharp Health Plan, UnitedHealthcare, and Western Health Advantage. Medicare plan options include Kaiser Permanente Senior Advantage, UnitedHealthcare Medicare Advantage PPO, Anthem Medicare Preferred, and the PERS Select/PERS Choice/ PERSCare PPO Medicare supplement plans.

The new Anthem Medicare Preferred Plan will be available for the 2018 year in 36 counties coupled with its Basic HMO Traditional plan. Contracting agency Medicare members will have an option to purchase dental and vision benefits from Anthem.

Kaiser Permanente is expanding its coverage to 13 counties in Washington State in 2018: Grays Harbor, Island, King, Kitsap, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, and Whatcom.

Western Health Advantage, a new plan partner for 2018, will provide coverage in the counties of Colusa, El Dorado, Marin, Napa, Placer, Sacramento, Solano, Sonoma, and Yolo.

Health Net SmartCare is moving into Placer County, while the Anthem Blue Cross Select HMO is adding Monterey County to replace the Anthem Monterey Exclusive Provider Organization plan (subject to regulatory approval).

We encourage you to visit the **Health Benefits** section of the CalPERS website at **www.calpers.ca.gov** to see the 2018 premiums for all health plans. You'll also find charts listing the scheduled premium rate changes and estimated premium payments for each health plan.

Benefit Changes in 2018

CalPERS introduced five health plan benefit changes for the PERS Select, PERS Choice, and PERSCare PPO plans, including:

- Expanding the use of Ambulatory Surgery Centers for Basic plans to include 12 new outpatient medical procedures, including sigmoidoscopies, tonsillectomies, and kidney stone treatments. A full list of the procedures will be listed in each health plan's Evidence of Coverage.
- Adding a site of care program to guide members who need certain prescription drug infusions to lower-cost sites than hospitals (e.g., doctor's office, ambulatory infusion center, or home infusion).

- A mobile application called Quick Care to help members quickly identify nearby clinics and doctors' walk-in offices, avoiding the need to use more expensive emergency room care for their urgent care needs.
- Expanding the Welvie Program to include Medicare subscribers. Welvie is an online tool that educates members, and informs and empowers their decision making when it comes to preference-sensitive surgeries.
- Adding the well-regarded, and much sought after, SilverSneakers program to the CalPERS PPO Medicare plans. SilverSneakers is a community fitness program specifically designed for older adults.

Changing Your Health Plan

Open Enrollment starts September 11 and ends October 6, 2017. All changes made during Open Enrollment become effective January 1, 2018. Here's how you can change your health plan during Open Enrollment:

- Active Employees – Contact your Health Benefits Officer or Human Resources Department for required forms and documentation.
- Retirees – CalPERS is your Health Benefits Officer. You may change your plan online during Open Enrollment through my|CalPERS at **my.calpers.ca.gov**. You may also mail your request to CalPERS Health Account Management Division P.O. Box 942715, Sacramento, CA 94229-2715, or call us toll free at **888 CalPERS** (**888**-225-7377).

Important Health Enrollment Reminders

- Be aware that a medical group ending its contract with a health plan does not create a qualifying event to change plans outside of Open Enrollment.
- You will receive new health plan ID cards if you change your health plan or enroll for the first time.
- Carefully review your pay warrant to ensure the correct health plan premium deduction was made when you change health plans, enroll for the first time, or add/delete dependents.
- If you change plans during Open Enrollment and you don't see the correct deduction applied by your February warrant, contact your Health Benefits Officer or Human Resources Department (or CalPERS, if you are a retiree).
- If you change health plans, do not continue to use your previous health plan after December 31, 2017.

Summary of Benefits and Coverage

Choosing a health plan is an important decision. To assist with this process each CalPERS health plan produces a Summary of Benefits and Coverage (SBC) that provides important information to help you better understand your health benefits and more easily compare health plans. The Uniform Glossary contains common insurance terms to help you better understand the SBCs. To view the SBCs and Uniform Glossary online, visit **www.calpers.ca.gov** under the **Plans and Rates** section, or the health plan websites. To request a free copy of the SBCs, please contact the health plan directly.

Additional Information for State and CSU Members

The Open Enrollment period for State of California and California State University (CSU)–sponsored dental and vision plans is September 11 – October 6, 2017. Dental and vision programs are administered by the California Department of Human Resources (CalHR) for state employees, and by the Office of the Chancellor for CSU employees. For dental and vision contact information, visit the CalPERS website at **www.calpers.ca.gov**.

Did You Know?

As a CalPERS member you can use my|CalPERS to explore, learn, and decide on your health plan options. To help you manage your Open Enrollment decisions, your Health Plan Statement, 2017 Open Enrollment resources, and CalPERS publications are available online through my|CalPERS.

A new health plan comparison tool, **Find a Medical Plan**, is now available on my|CalPERS. It will help you review health plans available in 2018, allowing you to set up side-by-side comparisons of plan features and premiums. Simply log into your my|CalPERS account at **my.calpers.ca.gov**, and select the **Health** tab, and then the **Find a Medical Plan** option.

Health Plan Availability by County: **Basic Plans**

Some health plans are available only in certain counties and/or ZIP Codes. Use the chart below to determine if the health plan you are considering provides services where you reside or work. Contact the plan before enrolling to make sure they cover your ZIP Code and that their provider network is accepting new patients in your area. You may also use our online service, the *Health Plan Search by ZIP Code,* available at **www.calpers.ca.gov**.

- ● Health plan covers all or part of county.
- ▲ Available out-of-state for PERS Choice and PERSCare, not available for PERS Select.

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+ HMO	Blue Shield Access+ EPO	CAHP	CCPOA	Health Net Salud y Más	Health Net SmartCare	Kaiser Permanente	PERS Select, PERS Choice, & PERSCare	PORAC	Sharp Performance Plus	UnitedHealthcare Signature Value Alliance	Western Health Advantage HMO
Alameda		●	●	●		●	●		●	●	●	●		●	
Alpine						●					●	●			
Amador						●				●	●	●			
Butte			●	●		●	●				●	●			
Calaveras						●					●	●			
Colusa					●	●					●	●			●
Contra Costa		●	●	●		●	●		●	●	●	●		●	
Del Norte	●					●					●	●			
El Dorado		●	●	●		●	●			●	●	●			●
Fresno		●	●	●		●	●		●	●	●	●		●	
Glenn			●	●		●					●	●			
Humboldt			●	●		●					●	●			
Imperial		●	●	●		●	●				●	●			
Inyo						●					●	●			
Kern		●	●	●		●	●	●	●	●	●	●		●	
Kings			●	●		●	●		●	●	●	●		●	
Lake						●					●	●			
Lassen						●					●	●			
Los Angeles		●	●	●		●	●	●	●	●	●	●		●	
Madera			●	●		●	●			●	●	●		●	
Marin			●	●		●	●		●	●	●	●		●	●
Mariposa				●		●	●			●	●	●			
Mendocino			●		●	●					●	●			
Merced		●	●	●		●	●				●	●		●	
Modoc						●					●	●			
Mono						●					●	●			
Monterey		●				●					●	●			
Napa			●			●			●	●	●	●			●
Nevada		●	●	●		●	●				●	●			
Orange		●	●	●		●	●	●	●	●	●	●		●	

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+ HMO	Blue Shield Access+ EPO	CAHP	CCPOA	Health Net Salud y Más	Health Net SmartCare	Kaiser Permanente	PERS Select, PERS Choice, & PERSCare	PORAC	Sharp Performance Plus	UnitedHealthcare Signature Value Alliance	Western Health Advantage HMO
Placer		●	●	●		●	●		●	●	●	●		●	●
Plumas						●					●	●			
Riverside		●	●	●		●	●	●	●	●	●	●		●	
Sacramento		●	●	●		●	●		●	●	●	●		●	●
San Benito			●			●					●	●			
San Bernardino		●	●	●		●	●	●	●	●	●	●		●	
San Diego		●		●		●	●	●	●	●	●	●	●	●	
San Francisco		●	●	●		●	●		●	●	●	●		●	
San Joaquin		●	●	●		●	●		●	●	●	●		●	
San Luis Obispo			●	●		●	●				●	●		●	
San Mateo			●	●		●	●		●	●	●	●		●	
Santa Barbara			●	●		●	●				●	●			
Santa Clara		●	●	●		●	●		●	●	●	●		●	
Santa Cruz		●	●	●		●	●		●	●	●	●		●	
Shasta						●					●	●			
Sierra					●	●					●	●			
Siskiyou						●					●	●			
Solano			●	●		●	●		●	●	●	●		●	●
Sonoma			●	●		●	●		●	●	●	●		●	●
Stanislaus		●	●	●		●	●			●	●	●		●	
Sutter						●				●	●	●			
Tehama						●					●	●			
Trinity						●					●	●			
Tulare		●	●	●		●	●		●	●	●	●			
Tuolumne						●					●	●			
Ventura		●	●	●		●	●			●	●	●		●	
Yolo		●	●	●		●	●		●	●	●	●		●	●
Yuba						●				●	●	●			
Out-of-State										●	▲	●			

Tools to Help You Choose Your Health Plan

This section provides a variety of information that can help you evaluate your health plan choices. Included here are details about using your my|CalPERS account, the *Find a Medical Plan* tool, and the *Health Plan Choice Worksheet*.

Accessing Health Plan Information with my|CalPERS

You can use my|CalPERS at **my.calpers.ca.gov**, our secure, personalized website, to get one-stop access to all of your current health plan information, including details about which family members are enrolled. You can also use it to search for other health plans that are available in your area, compare health plans, access CalPERS Health Program forms, and find additional information about CalPERS health plans. If you are a **retiree,** CalPERS is your Health Benefits Officer. Retirees may change their health plan during Open Enrollment by calling CalPERS toll free at **888 CalPERS** (or **888**-225-7377) or by using your my|CalPERS account.

my|CalPERS Health Plan Comparison Feature

Health Plan Resources

Choosing a health plan that's right for you is unique for every person or family. my|CalPERS includes additional resources to help you choose a health plan. These resources provide access to more detailed health benefit information that can help you determine what is most important to you in determining the plan that best fits your needs.

Evaluate Plan Features

Available health plans for you will be displayed based on the physical or mailing health eligibility ZIP Code in our system.

Create a customized plan search where you'll be able to review:

- Monthly premiums for each plan available to you
- Side-by-side comparisons of covered benefits, deductibles, and co-payments

Save Your Searches

Save as many as ten comparison scenarios with ability to review, rename, or delete at a later date.

Log in to your my|CalPERS account at **my.calpers.ca.gov** and select the "Health" tab and then select "Find a Medical Plan" to see what's available to you. To speak with someone at CalPERS about your health plan choices, call **888 CalPERS** (or **888**-225-7377).

Comparing Your Options: Find a Medical Plan

Access your my|CalPERS account for a convenient way to evaluate your health plan options and make a decision about which plan is best for you and your family. With this easy-to-use health plan comparison tool, you can weigh plan benefits and costs, and view how the plans compare.

You can access your account 24/7 to help you make health plan decisions at any time. You can use it to:

- Review health plan options during Open Enrollment.
- Evaluate your health plan options and estimate costs.
- Review a health plan option when your employer first begins offering the CalPERS Health Benefits Program.
- Review health plan options due to changes in your marital status or enrollment area.
- Explore health plan options because you are planning for retirement or have become Medicare eligible.

Be sure to tell us what you think about your my|CalPERS plan search experience by completing a survey at the end of your research.

Get customized assistance selecting the health plan that is right for you and your family by logging into your my|CalPERS account at **my.calpers.ca.gov**, selecting the "Health" tab and then selecting "Find a Medical Plan."

Comparing Your Options: Health Plan Choice Worksheet

An alternative tool we provide to help you choose the best plan for yourself and your family is the *Health Plan Choice Worksheet,* which you can find on page 12 of this booklet. This worksheet can be used to compare factors such as cost, availability, benefits, and quality of care measures. Simply follow the steps listed in the left column of the Worksheet. Several questions can be answered with a simple "yes" or "no," while others will require you to insert information or call the health plan. Some of the information can be found on the CalPERS website at **www.calpers.ca.gov**. If you need assistance completing the form, contact CalPERS at **888 CalPERS** (or **888**-225-7377).

Health Plan Choice Worksheet

Plan name and phone numbers:								
Select the type of plan: *(circle choice)*	HMO	PPO	EPO	Assoc. Plan[1]	HMO	PPO	EPO	Assoc. Plan[1]
Step 1 — Cost								
Calculate your monthly cost. Enter the monthly premium (see current year's rate schedule). Premium amounts will vary based on 1-party/2-party/family and Basic/Medicare.								
Enter your employer's contribution. For contribution amounts, active members should contact their employer; retired members should contact CalPERS.								
Calculate your cost. Subtract your employer's contribution from the monthly premium. If the total is $0 or less, your cost is $0.								
Step 2 — Availability								
Search available plans online. Use our online service, the Health Plan Search by Zip Code, at **www.calpers.ca.gov** to find out if the plan is available in your residential or work ZIP Code. You may also call the plan's customer service center.								
Call the doctor's office. Confirm that they contract with the plan and are accepting new patients. Ask what specialists are available and the hospitals with which they are affiliated.								
Step 3 — Comparisons								
How does the plan rate in quality of care measures? See page 15 to find out.								
Compare the benefits. See pages 16–31. CalPERS plans offer a standard package of benefits, but there are some differences: acupuncture, chiropractic, etc.								
Step 4 — Other								
Other considerations: Does the plan offer health education? Do you or your family have special medical needs? What services are available when you travel? Are the provider locations convenient?								
What changes are you planning in the upcoming year (e.g., retirement, transfer, move, etc.)?								
Other information								
Compare and select a plan.								

[1] You must belong to the specific employee association and pay applicable dues to enroll in the Association Plans.

Additional Resources

As a health care consumer, you have access to many resources, services, and tools that can help you find the right health plan, doctor, medical group, and hospital for yourself and your family.

Health Plan Directory

Following is contact information for the health plans. Contact your health plan with questions about: ID cards; verification of provider participation; service area boundaries (covered ZIP Codes); benefits, deductibles, limitations, exclusions; and *Evidence of Coverage* booklets.

Anthem Blue Cross[2] HMO & EPO
(855) 839-4524
www.anthem.com/ca/calpers

Anthem Medicare Preferred[2] PPO
(833) 848-8730
www.anthem.com/ca/calpers

Blue Shield of California
(800) 334-5847
www.blueshieldca.com/calpers

California Association of Highway Patrolmen (CAHP)
(800) 734-2247
www.thecahp.org

California Correctional Peace Officers Association (CCPOA)
Medical Plan
(800) 257-6213
www.ccpoabtf.org

Health Net of California[1]
(888) 926-4921
www.healthnet.com/calpers

Kaiser Permanente
(800) 464-4000
www.kp.org/calpers

OptumRx
Pharmacy Benefit Manager
Active Member Services
(855) 505-8110
Medicare Member Services
(855) 505-8106
www.optumrx.com/calpers

PERS Select,[2] PERS Choice,[2] PERSCare[2]
Administered by Anthem Blue Cross
(877) 737-7776
www.anthem.com/ca/calpers
Supplement to Medicare
(877) 737-7776

Peace Officers Research Association of California (PORAC)
(800) 288-6928
http://ibtofporac.org

Sharp Health Plan[1]
(855) 995-5004
www.sharphealthplan.com/calpers

UnitedHealthcare[1]
Active Member Services
(877) 359-3714
Retiree Member Services
(888) 867-5581
www.uhc.com/calpers

Western Health Advantage[1]
(888) 942-7377
www.westernhealth.com/calpers

[1] Pharmacy benefits administered by OptumRx for the Basic plan only.

[2] Pharmacy benefits administered by OptumRx for both Basic and Medicare plans.

Obtaining Health Care Quality Information

Following is a list of resources you can use to evaluate and select a doctor and hospital.

Hospitals

CalQualityCare

www.CalQualityCare.org

From hospitals to home care, CalQualityCare.org makes it easy to find providers and compare the quality of health care in California.

U.S. Department of Health and Human Services

www.medicare.gov/hospitalcompare

Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals across the country.

The Leapfrog Group

www.leapfroggroup.org

This is a coalition of health purchasers who have found that hospitals meeting certain standards have better care results.

Doctors and Medical Groups

Medical Board of California

www.mbc.ca.gov

This is the California State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.

Have you done a checkup on your doctor's license?

The Medical Board of California encourages consumers to check up on their doctor's license. Such a checkup is simple and helps you make an informed choice when choosing a doctor. To determine a doctor's status, go to the Medical Board's website at www.mbc.ca.gov or if you do not have a computer, call (800) 633-2322 and Medical Board staff will look up the doctor for you.

Office of the Patient Advocate

www.opa.ca.gov

This website includes a State of California-sponsored "Report Card" that contains additional clinical and member experience data on HMOs, PPOs and medical groups in California.

Benefit Comparison Charts

The benefit comparison charts on pages 16–31 summarize the benefit information for each health plan. For more details, see each plan's *Evidence of Coverage* (EOC) booklet.

CalPERS Health Plan Benefit Comparison—**Basic Plans**

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

	EPO & HMO Basic Plans							
BENEFITS	**Anthem Blue Cross EPO Select HMO Traditional HMO**	**Blue Shield Access+ HMO & Access+ EPO**	**Health Net Salud y Más & SmartCare**	**Kaiser Permanente**	**Sharp Performance Plus**	**UnitedHealthcare SignatureValue Alliance**	**CCPOA *(Association Plan)***	**Western Health Advantage HMO**
Calendar Year Deductible								
Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Co-pay or Co-insurance *(excluding pharmacy)*								
Individual	$1,500 (co-pay)	$1,500 (co-pay)	$1,500 (co-pay)	$1,500 (co-pay)	$1,500 (co-pay)	$1,500 (co-pay)	$1,500 (co-pay)	$1,500 (co-pay)
Family	$3,000 (co-pay)	$3,000 (co-pay)	$3,000 (co-pay)	$3,000 (co-pay)	$3,000 (co-pay)	$3,000 (co-pay)	$4,500 (co-pay)	$3,000 (co-pay)
Hospital *(including Mental Health and Substance Abuse)*								
Deductible (per admission)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	$100/ admission	No Charge
Outpatient Facility/ Surgery Services	No Charge	No Charge	No Charge	$15	No Charge	No Charge	$50	No Charge

Continued on next page

BENEFITS	PPO Basic Plans									
	PERS Select		PERS Choice		PERSCare		CAHP *(Association Plan)*		PORAC *(Association Plan)*	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible										
Individual	$500 (not transferable between plans)		$500 (not transferable between plans)		$500 (not transferable between plans)		N/A		$300	$600
Family	$1,000 (not transferable between plans)		$1,000 (not transferable between plans)		$1,000 (not transferable between plans)		N/A		$900	$1,800
Maximum Calendar Year Co-pay or Co-insurance *(excluding pharmacy)*										
Individual	$3,000 (co-insurance)	N/A	$3,000 (co-insurance)	N/A	$2,000 (co-insurance)	N/A	$2,000 (co-insurance)	N/A	$3,000	N/A
Family	$6,000 (co-insurance)	N/A	$6,000 (co-insurance)	N/A	$4,000 (co-insurance)	N/A	$4,000 (co-insurance)	N/A	$6,000	N/A
Hospital *(including Mental Health and Substance Abuse)*										
Deductible (per admission)	N/A		N/A		$250		N/A		N/A	
Inpatient	20–30% (hospital tiers)	40%	20%	40%	10%	40%	10%	Varies	10%	
Outpatient Facility/ Surgery Services	20–30% (hospital tiers)	40%	20%	40%	10%	40%	10%	40%	10%	

CalPERS Health Plan Benefit Comparison—**Basic Plans,** *Continued*

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

	EPO & HMO Basic Plans							
BENEFITS	**Anthem Blue Cross EPO Select HMO Traditional HMO**	**Blue Shield Access+ HMO & Access+ EPO**	**Health Net Salud y Más & SmartCare**	**Kaiser Permanente**	**Sharp Performance Plus**	**UnitedHealthcare SignatureValue Alliance**	**CCPOA** *(Association Plan)*	**Western Health Advantage HMO**
Emergency Services								
Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	$50	$50	$50	$50	$50	$50	$75	$50
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	$50	$50	$50	$50	$50	$50	$75	$50
Physician Services *(including Mental Health and Substance Abuse)*								
Office Visits (co-pay for each service provided)	$15	$15	$15	$15	$15	$15	$15	$15
Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Visits	$15	$15	$15	$15	$15	$15	$15	$15
Urgent Care Visits	$15	$15	$15	$15	$15	$15	$15	$15
Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Surgery/Anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab								
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

Continued on next page

BENEFITS	PPO Basic Plans									
	PERS Select		PERS Choice		PERSCare		CAHP *(Association Plan)*		PORAC *(Association Plan)*	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Emergency Services										
Emergency Room Deductible	$50 (applies to hospital emergency room charges only)		$50 (applies to hospital emergency room charges only)		$50 (applies to hospital emergency room charges only)		$50 (co-pay reduced to $25 if admitted on an inpatient basis)		N/A	
Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	20% (applies to other services such as physician, x-ray, lab, etc.)		20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		10%	
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	20%	40% (payment for physician charges only; emergency room facility charge is not covered)	20%	40% (payment for physician charges only; emergency room facility charge is not covered)	10%	40% (payment for physician charges only; emergency room facility charge is not covered)	$50+10%	$50+40% (co-pay reduced to $25 if admitted on an inpatient basis)	50% (for non-emergency services provided by hospital emergency room)	
Physician Services *(including Mental Health and Substance Abuse)*										
Office Visits (co-pay for each service provided)	$20	40%	$20	40%	$20	40%	$15	40%	$20	10%
Inpatient Visits	20%	40%	20%	40%	10%	40%	10%	40%	10%	10%
Outpatient Visits	$20	40%	$20	40%	$20	40%	10%	40%	10%	10%
Urgent Care Visits	$20	40%	$20	40%	$20	40%	$15	40%	10%	10%
Preventive Services	No Charge	40%	No Charge	40%	No Charge	40%	No Charge	40%	No Charge	
Surgery/Anesthesia	20%	40%	20%	40%	10%	40%	10%	40%	10%	10%
Diagnostic X-Ray/Lab										
	20%	40%	20%	40%	10%	40%	10%	40%	10%	10%

CalPERS Health Plan Benefit Comparison—**Basic Plans,** *Continued*

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

	EPO & HMO Basic Plans							
BENEFITS	**Anthem Blue Cross** EPO Select HMO Traditional HMO	**Blue Shield** Access+ HMO & Access+ EPO	**Health Net** Salud y Más & SmartCare	**Kaiser Permanente**	**Sharp Performance Plus**	**UnitedHealthcare SignatureValue Alliance**	**CCPOA** *(Association Plan)*	**Western Health Advantage HMO**
Prescription Drugs								
Deductible	N/A	N/A	N/A	N/A	N/A	N/A	Tier 2, 3, and 4: $50 (not to exceed $150/family)	N/A
Retail Pharmacy (not to exceed 30-day supply)	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand: $20	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Tier 1: $10 Tier 2: $25 Tier 3 and 4: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50
Retail Pharmacy Maintenance Medications filled after 2nd fill *(i.e. a medication taken longer than 60 days)* (not to exceed 30-day supply)	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	N/A	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Tier 1: $10 Tier 2: $25 Tier 3 and 4: $50	Generic: $10 Brand Formulary: $40 Non-Formulary: $100
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand: $40 (31-100 day supply)	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Tier 1: $20 Tier 2: $50 Tier 3: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100
Mail order maximum co-payment per person per calendar year	$1,000	$1,000	$1,000	N/A	$1,000	$1,000	N/A	$1,000
Durable Medical Equipment								
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

Continued on next page

BENEFITS	PPO Basic Plans									
	PERS Select		PERS Choice		PERSCare		CAHP *(Association Plan)*		PORAC *(Association Plan)*	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Prescription Drugs										
Deductible	N/A		N/A		N/A		N/A		N/A	
Retail Pharmacy (not to exceed 30-day supply)	Generic: $5 Preferred: $20 Non-Preferred: $50		Generic: $5 Preferred: $20 Non-Preferred: $50		Generic: $5 Preferred: $20 Non-Preferred: $50 (not to exceed 34-day supply)		Generic: $6 Single Source: $25 Multi Source: $35		Generic: $10 Brand Formulary: $25 Non-Formulary: $45 Compound: $45	
Retail Pharmacy Maintenance Medications filled after 2nd fill *(i.e. a medication taken longer than 60 days)* (not to exceed 30-day supply)	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100 (not to exceed 34-day supply)		Generic: $12 Single Source: $50 Multi Source: $70		N/A	
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $12 Single Source: $50 Multi Source: $70		Generic: $20 Brand Formulary: $40 Non-Formulary: $75	N/A
Mail order maximum co-payment per person per calendar year	$1,000		$1,000		$1,000		N/A		N/A	
Durable Medical Equipment										
	20%	40%	20%	40%	10%	40%	10%	40%	20%	20%
	(pre-certification required for equipment)		(pre-certification required for equipment)		(pre-certification required for equipment $1,000 or more)					

CalPERS Health Plan Benefit Comparison—**Basic Plans,** *Continued*

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

	EPO & HMO Basic Plans							
BENEFITS	**Anthem Blue Cross** EPO Select HMO Traditional HMO	**Blue Shield** Access+ HMO & Access+ EPO	**Health Net** Salud y Más & SmartCare	**Kaiser Permanente**	**Sharp Performance Plus**	**UnitedHealthcare SignatureValue Alliance**	**CCPOA** *(Association Plan)*	**Western Health Advantage HMO**
Infertility Testing/Treatment	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Allowed Charges	50% of Covered Charges
Occupational / Physical / Speech Therapy								
Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient (office and home visits)	$15	$15	$15	$15	$15	$15	No Charge	$15
Diabetes Services								
Glucose monitors	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Self-management training	$15	$15	$15	$15	$15	$15	$15	$15
Acupuncture	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	N/A	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
Chiropractic	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15 exam (up to 20 visits) No Charge diagnostic services; chiropractic appliances (up to $50)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)

Continued on next page

BENEFITS	PPO Basic Plans									
	PERS Select		PERS Choice		PERSCare		CAHP *(Association Plan)*		PORAC *(Association Plan)*	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Infertility Testing/Treatment										
	Not Covered		Not Covered		Not Covered		Not Covered		50%	50%
Occupational / Physical / Speech Therapy										
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		No Charge		10%	40%	$20; Speech therapy: 10%	10%
Outpatient (office and home visits)	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	10% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 10%	10% (pre-certification required for more than 24 visits)	40%	$20	10%
Diabetes Services										
Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
Self-management training	$20	60% non-PPO	$20	60% non-PPO	$20	60% non-PPO	$15	60% non-PPO	$20	60% non-PPO
Acupuncture										
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	10% (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$20 (10% for all other services)	10%
Chiropractic										
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	10% (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$20/up to 20 visits	10%

DELTA DENTAL

Keep Smiling

DeltaCare® USA

provided by
Delta Dental of California

Dental benefits made easy!

When you enroll in a DeltaCare USA[1] plan, you'll choose a primary care dentist from our network of carefully screened, private practice dentists. You must visit your primary care dentist to receive benefits.[2]

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health

Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

With your DeltaCare USA plan, there are no surprises. You'll know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums[3] for covered services
- Pay only your copayment (if any) at the time of treatment

Convenient services

We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- Access plan information online
- Change your primary care dentist by phone or online

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

[1] DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, MI, MN, NE, OR, RI, SC, WA, WI — Dentegra Insurance Company; DC, DE, FL, GA, KS, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA — Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

[2] We recommend that you verify online that the dentist is your selected DeltaCare USA primary care dentist before each appointment.

[3] Plans with an Accidental Injury Rider have a $1600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.

We keep you smiling®
deltadentalins.com/enrollees

SCCACRT

Administered by Delta Dental Insurance Company

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Answers to frequently asked questions about your DeltaCare USA plan

GETTING STARTED

1. **How do I enroll in a DeltaCare USA plan?**
   Simply complete the enrollment process as directed by your benefits administrator. Be sure to select a primary care network dentist for yourself or your dependents, and indicate this dentist and the name of your group when you enroll.

2. **How do I get started using my DeltaCare USA plan?**
   Once we process your enrollment, we'll mail you welcome materials that will include:

   - **The name, address and phone number of your selected primary care dentist:** Simply call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit your primary care network dentist for all services. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You can change your primary care dentist by contacting us.
   - **Your Evidence/Certificate of Coverage (plan booklet):** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
   - **An ID card:** This card is for your records only — you do not need to present it in order to receive treatment.

3. **How long will it take to get an appointment with my primary care dentist?**
   Two to four weeks[1] is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may need to wait longer. Most DeltaCare USA dentists are in private group practices, which generally offer greater appointment availability and extended office hours.

4. **How much will my dental treatments cost? How do I pay?**
   With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" in this brochure for a list of covered services and copayments. It's a good idea to bring your Evidence/Certificate of Coverage to your appointment in case you need to discuss your copayment for a service with your dentist. If you have any questions about the charges for a service, please contact our Customer Service department. If you receive treatment that requires a copayment, simply pay the dental facility at the time of service.

CHOOSING A DENTIST

5. **How do I select my primary care dentist?**
   When you enroll, you must select a primary care dentist from the DeltaCare USA network. To search for a dentist, use the "Find a Dentist" tool at **deltadentalins.com** and select DeltaCare USA as your network. If you do not select a dentist when you enroll, we will choose one for you.

6. **Does everyone in my family have to choose the same primary care dentist?**
   Your family members can visit the same primary care network dentist, but you do not have to. You may collectively select a maximum of three different primary care network dentists.[2]

7. **Can I change my primary care dentist?**
   Yes. You can request to change your primary care dentist at any time. Simply visit our website and log on to your Online Services account or call or write to Customer Service. Change requests received by the 21st of the month will become effective the first day of the following month.

[1] In TX, three weeks is a reasonable amount of time to wait for a routine, non-urgent appointment.
[2] In TX, there is no limit. Each eligible family member may select his or her own primary care network dentist.

8. **My dentist says she is a Delta Dental dentist, but she isn't listed in the DeltaCare USA directory. Can I still visit her for services?**
No. You must visit your selected primary care network dentist to receive benefits under this plan. Delta Dental has many networks, and participation may vary — not all Delta Dental dentists are DeltaCare USA dentists.

9. **What should I do if I need to see a specialist?**
If you require specialty dental care — such as oral surgery, endodontics, periodontics or pediatric dentistry — contact your primary care dentist to request a referral. Specialty dental services not performed by your selected primary care dentist must be authorized by us. You are responsible for any applicable copayments.

GENERAL PLAN INFORMATION

10. **If I'm traveling, is emergency treatment covered under my plan?**
You and your eligible dependents have out-of-area coverage for dental emergencies when you are more than 35 miles[3] from your primary care dentist. Your out-of-area emergency benefit (typically limited to $100 per enrollee[3] every 12 months[4]) is for services to relieve pain until you can return to your primary care network dentist. Standard plan limitations, exclusions and copayments may apply.

11. **Can I access my plan online?**
Yes. Visit **deltadentalins.com/enrollees** to create a free, secure Online Services account. On our website, you can access your plan benefits and ID card, select (or change) your primary care dentist — and more.

12. **Does my plan cover pre-existing conditions? What about treatments that are in progress?**
Treatment for pre-existing conditions (except work in progress[5]), including missing or extracted teeth, is covered under your plan. Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

13. **Does my plan cover teeth whitening?**
Yes. External bleaching is a benefit under your DeltaCare USA plan. Review your plan booklet for more information and talk to your dentist about your options.

14. **Does my plan cover tooth-colored fillings and crowns?**
Yes. Porcelain and other tooth-colored materials are included in this plan.

15. **What if I have additional questions about my plan?**
Please contact us for additional support. Our Customer Service agents can answer benefits questions as well as help you change your primary care dentist or arrange for urgent care referrals. See the back page of this brochure for our contact information.

[3] In TX, there is no limit on the number of miles or on the dollar amount per emergency.
[4] Exceptions may apply. Refer to your Evidence/Certificate of Coverage.
[5] In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

DELTA DENTAL

Keep Smiling

Delta Dental PPO℠

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.[4]

Set up an online account

Get information about your plan anytime, anywhere by signing up for an Online Services account at **deltadentalins.com**. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply sign in to Online Services, where you can view or print your card with the click of a button.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.[5] You can find this date by logging in to Online Services.

Newly covered?

Visit **deltadentalins.com/welcome**.

Save with a PPO dentist

PPO

NON-PPO

[1] In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

[4] We recommend verifying before each appointment that your dentist is a PPO dentist.

[5] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

LEGAL NOTICES: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html.

HL_PPO #96083E (rev. 5/16)

BENEFIT HIGHLIGHTS
DELTA DENTAL PPO℠

GROUP NAME: Town of Los Gatos
GROUP NUMBER: 09284

> ELIGIBILITY: WHO MAY RECEIVE BENEFITS?

- **Primary enrollee and spouse**
  (includes domestic partner)
- **Eligible dependent children to:**
  end of month dependent turns age 26

> WAITING PERIODS

Basic Services: none Major Services: none
Orthodontics: none

> DEDUCTIBLES per person/per family
$25 / $75 each cal. year (PPO network)
$50 / $150 each cal. year (outside PPO network)

> MAXIMUMS per person
$1,500 each cal. year

BENEFITS AND COVERED SERVICES	PPO dentists[1,2]	Non-PPO dentists[1,2,3]
Diagnostic & Preventive Services (D&P) Exams, cleanings and x-rays	100% Deductible doesn't apply to D&P D&P counts towards maximum	100%
Basic Services Fillings and sealants	90%	80%
Endodontics (Basic) Root canals	90%	80%
Periodontics Gum treatment (Basic)	90%	80%
Oral Surgery (Basic)	90%	80%
Major Services Crowns, inlays, onlays and cast restorations	60%	50%
Prosthodontics (Major) Bridges, dentures and implants	60%	50%
Orthodontics For adults and dependent children Lifetime per person	50% $1,500	50% $1,500

1 Delta Dental Premier® dentists are considered non-PPO dentists.
2 Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.
3 Non-Delta Dental dentists may balance bill the difference between the contracted rate and their usual fee for services.

Delta Dental of California
100 First Street
San Francisco, CA 94105

Customer Service
(Toll-Free)
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

This benefit information is not intended to replace or serve as the plan's Evidence of Coverage, Summary Plan Description or Group Dental Service Contract. If you have specific questions regarding the benefits eligibility, limitations or exclusions of your plan, please consult your company's benefits representative.

HL_2col_PPO_Ortho #96054 (rev. 03/16)

Get access to the best in eye care and eyewear with TOWN OF LOS GATOS and VSP® Vision Care.

VSP® Vision care for life

Why enroll in VSP? As a member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at the lowest out-of-pocket costs.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP network doctor, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP network doctor, your satisfaction is guaranteed.
- **Choice of Providers.** The decision is yours to make—choose a VSP network doctor or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com®**, VSP's online eyewear store.

Enroll in VSP today.
You'll be glad you did.
Contact us. **800.877.7195**
vsp.com

Your VSP Vision Benefits Summary

TOWN OF LOS GATOS and VSP provide you with an affordable eye care plan.

VSP Coverage Effective Date: 01/01/2018 **VSP Provider Network:** VSP Signature

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness	$20 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance	Combined with exam	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$50 $80 - $90 $120 - $160	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Primary Eyecare	• Treatment and diagnosis of eye conditions like pink eye, vision loss and monitoring of cataracts, glaucoma and diabetic retinopathy. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam ..... up to $50	Lined Bifocal Lenses ..... up to $75	Progressive Lenses ..... up to $75
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $100	Contacts ..... up to $105
Single Vision Lenses ..... up to $50		

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Contact us. **800.877.7195** | **vsp.com**

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

Give your members complete eye health coverage with the VSP Primary EyeCare Plan. This important plan goes beyond routine eyecare and provides additional coverage for medical and urgent eyecare services. Members can self-refer[1], visit their VSP provider as often as needed, and pay only a copay for services. Plus, they'll have the reassurance and convenience of visiting the same eyecare provider who knows their eyes best.

VSP Primary EyeCare Plan Summary

Specialty Eyecare Services

- The VSP Primary EyeCare Plan provides supplemental[2] coverage for non-surgical medical eye conditions[3] including:
  - diagnosis and tests for vision loss
  - treatment for conditions such as pink eye
  - management of glaucoma and diabetic eye disease
  - retinal screening for eligible members with diabetes
- VSP providers may use ocular photography to identify abrasions, growths, or other eye abnormalities.
- VSP providers also provide follow-up medical eyecare, including any necessary referrals and consultations with the patient's primary care physician.

VSP Providers

- VSP providers are in retail, neighborhood, and professional settings, with 88% offering extended hours.
- Our providers average 21 years in practice, with 99% network retention, so our members benefit from long-term, consistent care.
- 100% of our providers are credentialed to NCQA standards.
- All VSP providers use Evidence-Based Eyecare®, which includes best-practice medical guidelines, comprehensive eye exam standards, and coordination of care with the patient's primary care physician.

[1] Unless referral by a primary care physician is required by the health plan.
[2] The VSP Primary EyeCare Plan pays secondary to other medical eye insurance coverage.
[3] The VSP Primary EyeCare Plan provides a standardized set of services that can be performed by optometrists in most states. Contact your VSP representative for more information regarding specific coverage.

Get up to $110 back

Members can save big with VSP exclusive mail-in rebates on eligible popular contact lens brands from Bausch + Lomb and CooperVision.

$500 savings on LASIK

Members can save up to $500 on LASIK at NVision Eye Centers and TLC Laser Eye Centers.

Save up to $2,500

With Exclusive Member Extras, members can save more than $2,500 with special offers and rebates through VSP and other leading industry partners.

Learn More

Visit vsp.com/specialoffers.

Town of Los Gatos

Basic Life and AD&D Benefit Highlights

Eligibility:	All active, full time Employees of the Employer regularly working a minimum of 20 hours per week.
Employee Life and AD&D Benefit Amount:	*Flat $50,000*

Additional Plan Provisions:

Conversion :	If your Life insurance terminates, the plan's *Conversion* Privilege allows you to convert all or a portion of your group coverage to an individual policy from CIGNA Group Insurance. The conversion amount will depend on the reason coverage is terminating. You must request conversion and pay the required premium within 31 days of the date your Life insurance ends. No evidence of good health will be required. Available to age 70.
Portability:	Employee coverage only - 3 years duration - Limited to 50% to $25,000
Benefit Reduction Schedule:	Benefit will reduce to 67% at age 65; 45% at age 70.
AD&D Benefits :	If the employee suffers an accident or injury that results in a covered loss within 90 days of the accident and the loss results directly from the injury independent of other causes, CIGNA Group Insurance will pay as follows: 100% Benefit for loss of Life, Both Hands or Both Feet or Sight of Both Eyes, Speech and Hearing. 75% Benefit for total paralysis of both upper limbs (Paraplegia). 50% Benefit for loss of Either Hand or Foot, Sight in One Eye, Speech or Hearing or Total Paralysis of upper & lower limbs on one side of the body (Hemiplegia). 25% Benefits for loss of all four fingers same hand or all toes on same foot, Thumb & Index finger or Total Paralysis of one upper or one lower limb (Uniplegia).
Terminal Illness:	Should you be diagnosed as terminally ill with a 12-month or less life expectancy, this benefit allows you to receive an accelerated payment of a portion of your life insurance proceeds. You may request a minimum accelerated payment of 50% of the person's coverage to a maximum of $25,000. Funds are paid directly to you, with no policy restrictions on how you use them. The remaining benefit is then payable to the beneficiary. Coverage available to employees and spouses
Waiver of Premium:	This provision applies if you become totally disabled before age 60 and your disability lasts for at least 6 months. You must provide proof of your condition within one year of your last day of work and once we approve, your coverage will continue without payment of premium up to age 65, as long as you remain totally disabled. Payment of premium is required until waiver is approved by CIGNA Group Insurance (see Conversion above). Eligibility for waiver of premium continues if the group policy is terminated.
Benefit Costs:	Town of Los Gatos pays 100% of the cost for this coverage.
CIGNA Secure Travel:	Travel Assistance Program - Coverage for trips more than 100 miles from home. Medical evacuation and repatriation with no maximum limits.

This Benefit Highlights Sheet explains the general purposes of the insurance described, but in no way changes or affects the policy as actually issued. In the event of any discrepancy between this document and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance. Please read it carefully and keep it in a safe place with your other important papers.

Underwritten by: Life Insurance Company of North America

Term Life Insurance

Developed for the Employees of

Town of Los Gatos

Who Needs Life Insurance?

You do. Single or married. Buying your first home or preparing for retirement. Raising children or sending them off to college. No matter where you are in life, insurance should be part of your financial plan.

By purchasing this insurance product through your employer, you benefit from:

- Affordable group rates
- Convenient payroll deduction
- Access to knowledgeable service representatives.

Who Is Eligible For Coverage?

You — If you are an active, full-time employee or an elected official of the employer and work a minimum of 20 hours per week for your employer.

Your Spouse* — Up to age 70 is eligible provided that you apply for and are approved for coverage for yourself.

Your Unmarried, Dependent Children — At least 14 days old and under age 19 (or under age 25 if they are full-time students), as long as you apply for and are approved for coverage for yourself. One low premium will insure all your eligible children, regardless of the number of children you have. No one may be covered more than once under this plan. If covered as an employee, you can not also be covered as a dependent.

**Domestic Partner is defined in the group policy. For purposes of this brochure, wherever the term Spouse appears it shall also include Domestic Partner. You must have on file an affidavit (available from your employer) which specifies the criteria for being considered a Domestic Partner under the group policy. In addition, a Domestic Partner registered with the California Secretary of State is eligible as a Domestic Partner under the policy, and no affidavit is necessary. Additional information is available from your Benefit Services Representative.*

How Much Coverage Can You Buy?

You — You can select life insurance coverage in units of $10,000. The maximum for any employee is the lesser of 5 times your annual salary or $300,000. The guaranteed coverage amount for you is the lesser of 1 times your annual salary or $100,000.

Your Spouse — You may select coverage for your spouse in units of $5,000 to a maximum of $250,000. The cost of coverage will be based on your spouse's age. The guaranteed coverage amount for your spouse is $25,000.

Your Unmarried, Dependent Children — You may select coverage for your unmarried, dependent children in units of $1,000 to a maximum of $10,000. The maximum benefit for children under six months is $500. The guaranteed coverage amount for your child(ren) is $10,000.

Guaranteed Coverage

If you and your dependents are eligible and you apply during the initial enrollment period, or within 31 days after you are eligible to elect coverage, you are entitled to choose any of the offered amounts of coverage up to the guaranteed coverage amount, as shown on your application, without having to provide evidence of good health. If you apply for an amount of coverage for yourself or your spouse greater than the guaranteed coverage amount, coverage in *excess* of the guaranteed coverage amount will not be issued until the insurance company approves acceptable evidence of good health. Evidence of good health may include a paramedical exam or physician's statement. If you apply for coverage for yourself or your spouse more than 31 days from the date you become eligible to elect coverage under this plan, the guaranteed coverage amounts will not apply. Coverage will not be issued until the insurance company approves acceptable evidence of good health. Evidence of good health may include a paramedical exam or physician's statement.

How Much Your Coverage Will Cost

The monthly cost of insurance for you and your spouse will depend on your ages and the amount of insurance you wish to purchase. As shown in the following chart, the cost of insurance increases with the age of the insured. Note that at age 60, your benefits are reduced. Spouse coverage ceases at age 70.

To calculate your monthly cost:

1. Find your age group in the following table;
2. Multiply the rate by the number of coverage units you want;
3. Calculate the cost of coverage for your spouse, using your spouse's age, then calculate the cost of coverage for your children;
4. Add the premiums for you, your spouse and your children to get your total monthly cost.

Example::

Employee *(age 28)*	25 units ($250,000)	x	$0.60 per unit	=	$15.00
Spouse *(age 24)*	10 units ($50,000)	x	$0.245 per unit	=	$2.45
Children	10 units ($10,000)	x	$0.18 per unit	=	$1.80
			Total Monthly Cost		$19.25

To calculate your cost, complete this chart:

Employee	____ units	x	$___.___ per unit	=	$___.___
Spouse	____ units	x	$___.___ per unit	=	$___.___
Children	____ units	x	$0.18 per unit	=	$___.___
			Total Monthly Cost		$___.___

Employee/ Spouse Age	Employee Monthly Cost per $10,000 Unit	Spouse Monthly Cost per $5,000 Unit
Under 20	$0.31	$0.155
20 to 24	0.49	0.245
25 to 34	0.60	0.30
35 to 39	0.79	0.395
40 to 44	1.05	0.525
45 to 49	1.58	0.79
50 to 54	2.51	1.255
55 to 59	4.04	2.02
60 to 64	6.20	3.10
65 to 69	10.50	5.25
70 to 74	19.93	--
75 to 79	40.26	--
80 to 84	79.98	--
85 to 89	147.44	--
90 to 94	240.57	--
95 to 99	365.17	--

The monthly cost for children is $0.18 per $1,000 of coverage. One premium will insure all your eligible children, regardless of the number of children you have.

Costs are subject to change.

When You Reach Age 65

By the time you reach age 65, chances are that your children will be grown and your mortgage paid. At age 65, providing you are still employed, your coverage will decrease to 67% of the benefit amount. It will decrease to 45% at age 70. Premiums and coverage for your spouse will end at age 70; at that time your spouse may choose to convert this coverage to a permanent life insurance policy.

Other Benefit Features

Accelerated Death Benefit — Terminal Illness

If you or your spouse is diagnosed by two unaffiliated physicians as terminally ill with a life expectancy of 12 months or less, the accelerated payment benefit for terminal illness provides for up to 50% of the life insurance coverage amount in force or $250,000, whichever is less, to be paid to the insured. This benefit is payable only once in the insured's lifetime, and will reduce the life insurance death benefit.

The terminal illness benefit may be taxable. As with all tax matters, an insured should consult with a personal tax advisor to assess the impact of this benefit.

Increasing Your Coverage

You may increase your coverage at any time. We do require evidence of good health for all new coverage elections.

Continuation for Disability for Employees Age 60 or over

If your active service ends due to disability, this plan provides a continuation of coverage feature. If you are disabled at age 60 or over, your coverage will continue while you are disabled. This benefit will remain in force until the earliest of the following dates: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 9 consecutive months, or the day after the last period for which premiums are paid.

You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan. "Regular Occupation" means your occupation, as routinely performed in the general labor market, at the time your disability begins.

Extended Death Benefit with Waiver of Premium

Extended Death Benefit
If you become Disabled — The extended death benefit ensures that if you become disabled prior to age 60, and die before you qualify for Waiver of Premium, we will pay the life insurance benefit if you remain disabled during that period. If you qualify for this benefit and have insured your spouse or children, their coverage is also extended.

You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan. "Regular Occupation" means your occupation, as routinely performed in the general labor market, at the time your disability begins.

Waiver of Premium

If you become totally disabled — To make sure you can keep the life insurance protection you need during a difficult period of your life, this plan provides a *waiver of premium* feature. If you are totally disabled prior to age 60 and can't work for at least 6 months, you won't need to pay premiums for your coverage while you are disabled, provided the insurance company approves you for this benefit. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because of injury or sickness. This benefit will remain in force until age 65, subject to proof of continuing disability each year. If you qualify for this benefit and have insured your spouse or children, the premium for their coverage is also waived.

What Is Not Covered

The plan will not pay benefits if loss of life is the result of suicide that occurs within the first two years of coverage.

When Your Coverage Begins and Ends

The date your coverage begins is called its "effective date." Your employer will let you know the effective date of your coverage. If you are not actively at work on the effective date of coverage, your coverage will not begin until you return to work.

For coverage for your spouse and/or children to be effective, they must not be hospitalized or confined at home under the care of a doctor.

Your coverage cannot be terminated as long as you remain eligible, the premium is paid and the group policy remains in force.

For your spouse and children, coverage ends when your coverage ends, when their premiums are not paid or when they are no longer eligible.

If You Leave Your Employer

To help you keep your life insurance coverage during the years when your family needs financial protection, the plan allows you to continue all of your voluntary coverage if you leave your employer. Premiums may change at this time. Just make arrangements to pay your premiums directly to the insurance company after you leave your current employer. Coverage may be continued for you and your spouse until age 70. Coverage may also be continued for your children. As long as the group policy remains in force, the option of continuing this coverage is available.

Converting Your Coverage to Permanent Life Insurance

If group life insurance coverage is reduced or ends for any reason except nonpayment of premiums, you can convert to an individual policy. No medical certification is needed. To convert coverage, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Family members may convert their coverage as well. Converted policies are subject to certain benefits and limits as outlined in the conversion brochure which may be requested as needed. Premiums may change at this time.

Apply Today

In order to apply for coverage, you must complete an application form. Be sure to answer all questions accurately, and indicate how much coverage you wish to have.

Payroll Deduction

You pay your premiums through payroll deduction. The total depends on how much coverage you select, your age, your spouse's age and the amount of coverage you buy for your spouse and children.

Designating Your Beneficiary

Your term life benefit will automatically be paid to the first beneficiary listed below who is living at the time of your death if you do not designate a specific beneficiary:

1) Your Spouse* 2) Your Child(ren) 3) Your Parents
4) Your Siblings 5) Your Estate

If you wish to designate different beneficiaries, or to indicate percentages, you may do so on your application. If the listed beneficiary is a trustee or a trust, you will need to indicate the trustee's name, the name of the trust and the date of the trust agreement. The trust document must be presented in order for the claim to be processed.

** Benefits will not be paid to your Domestic Partner if he or she is not specifically designated.*

How Your Claims Are Paid

Your employer has all the forms your beneficiary will need and can provide assistance in completing them.

Questions?

Cigna Group Insurance has courteous, knowledgeable customer service representatives who can assist you with the completion of your enrollment form by calling 1-800-732-1603 toll-free anytime from Monday through Friday, 8 a.m. to 6 p.m. Eastern time. Cigna does not have your coverage election information on file. For specific benefit/account inquiries on what is available under your plan, please contact your Human Resources department.

This information is a brief description of important features of the plan. It is not a contract. Terms and conditions of coverage are set forth in Group Policy No. SGM-600963, on Policy Form TL-004700, issued in Delaware to the Trustee of the Group Insurance Trust for Employers in the Public Administration Industry. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.

Coverage is underwritten by
Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192

06/13

Town of Los Gatos

Short Term Disability Benefit Highlights

Eligibility:	All active full-time Employees of the Employer regularly working a minimum of 20 hours per week, excluding Employees who are classified as Elected Officials.
Eligibility Waiting Period:	Date of Hire
Weekly Income Benefit:	60%
Minimum Weekly Benefit:	$25
Maximum Weekly Benefit:	$1,300
Maximum Duration of Benefits:	13 weeks
Elimination Period:	Benefits commence on the 8th day
Partial Disability Earnings:	The Partial benefit is available if you go back to work on a part-time limited-duty basis immediately following the elimination period of total disability. In the event you've recovered enough to perform some of the duties of your occupation, earnings may not exceed 80% of pre-disability earnings.
Coverage Basis:	24 hours
Benefit Cost:	Town of Los Gatos pays 100% of the cost of your STD coverage.

This Benefit Highlights Sheet explains the general purposes of the insurance described, but in no way changes or affects the policy as actually issued. In the event of any discrepancy between this document and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with your other important papers.

Underwritten by:
Life Insurance Company of North America

Town of Los Gatos

Long Term Disability Benefit Highlights

Eligibility:	All active full-time Employees of the Employer regularly working a minimum of 20 hours per week, excluding Employees who are classified as Elected Officials.
Elimination Period:	90 days
Definition of Disability	Own Occupation for 36 months, Any Occupation thereafter.
Benefit Percentage / Maximum & Minimum Monthly Benefit:	Plan replaces 60% of your monthly income to a maximum of $6,000. Benefits will never be less than the greater of $100 or 10% of your benefit.
Pre-Existing Condition Limitation	3 Months Prior/12 Months Insured
Return to Work Incentive Benefit	In addition, your plan offers a return-to-work incentive. During the first 24 months you return to work following the completion of the elimination period, your current monthly earnings and monthly benefit combined may equal up to 100% of your pre-disability earnings. If the combined amount exceeds 100%, it will be reduced by the amount of the excess.
Benefit Duration:	As long as you remain totally disabled, LTD benefit payments will continue according to the following schedule. The later of the Employee's SSNRA or the following;

Age of Disability	Age 62 or prior	63	64	65	66	67	68	69+
Duration of Payments	The employee's 65th birthday	36	30	24	21	18	15	12

Definitions & Provisions:

Definition of Disability: You are considered Disabled if, solely because of Injury or Sickness, you are:
1: unable to perform the material duties of your Regular Occupation; or
2: unable to earn 80% or more of your Indexed Earnings from working in your Regular Occupation.

After disability benefits have been payable for 36 months, you are considered disabled if, solely due to Injury or Sickness, you are:
1: unable to perform the material duties of any occupation for which you are, or may reasonably become, qualified based on education, training or experience or
2: unable to earn 60% or more of your Indexed Earnings.

We will require proof of earnings and continued Disability.

Trial Work Days: No limit on trial work days during benefit waiting period provided earnings received do not exceed the earnings test over the entire period

Mental Illness Limitation: 24 Month Limitation

Substance Abuse Limitation: 24 Month Limitation

Subjective Symptom Limitation: 24 Month Limitation

Survivor Income Benefit: 3 months lump sum

Benefit Cost: Town of Los Gatos pays 100% of the cost for this coverage.

Underwritten by: Life Insurance Company of North America

CIGNA HEALTHY WORKING LIFE℠ PRE-DISABILITY VOCATIONAL SERVICES

Participant guide

People with medical conditions, who do not lose time from work, may have better health outcomes than people who do lose time. One of the keys to reducing the incidence of disability is early intervention – ideally before your employee even needs to file a disability claim. The conditions that lead to work absence are often known and under medical care months before a disability claim is filed.

That's why Cigna offers a stay-at-work solution to our disability clients – services designed to help your at-risk employees reduce the likelihood of going out on disability. Our Vocational Coaches help employees who have serious medical conditions remain at work and productive by better managing the limitations associated with their conditions.

While not all disabilities can be predicted or avoided, Cigna understands that many of the conditions that lead to work absence are often known and under medical care months before a disability claim is filed.

Pre-disability interventions are provided by Vocational Coaches to employees who are at risk for a disability absence but have not gone out of work yet.

What does a Vocational Coach do?

Vocational Coaches are part of the Cigna disability management team and are experts in:

- Assessing employees' skills, functional capacity and motivation, and then matching them to the requirements of a given job.
- Providing counseling and technical assistance to employees who may be struggling with illnesses or injuries that affect their ability to work.
- Training employers to meet the needs of employees with disabling conditions.
- Assessing an employee's needs, abilities and medical restrictions that will affect his or her ability to perform job tasks.
- Identifying barriers that may be preventing an employee from staying at work or returning to work.
- Providing one-on-one Coaching to help employees overcome those barriers.
- Identifying opportunities for:
  - Job task modifications.
  - Workstation ergonomic adjustments.
  - Transitional work assignments.
  - Assistive devices or attire.
- Collaborating with other health care professionals to support the employee's participation within their treatment plan.

The particular services provided depend on the employee's serious medical condition and other factors as determined by the Vocational Coach.

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Offered by: Life Insurance Company of North America or Cigna Life Insurance Company of New York.

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Based on the Vocational Coach's assessment, Cigna may engage a range of interventions that might include performing ergonomic assessments or authorizing payment for workplace equipment.

Who can benefit from pre-disability vocational services?

While the particular medical conditions that make someone suitable for these services are too varied to list, some signs that an individual may be a candidate for referral may include the following.

1. Is the employee experiencing increased absence due to his/her condition (calling out sick more or coming in late or leaving early)?
2. Does the employee have a past history of disability absence due to his/her condition?
3. Does the employee seem to be struggling to complete his/her job tasks?
4. Does the employee complain of pain or discomfort?
5. Has the employee requested replacement equipment, such as a different office chair, in order to be more comfortable?

Employees who would not be appropriate for pre-disability vocational services include:

- Individuals currently out of work on disability.
- Workers' compensation cases.
- Employees experiencing temporary pain/ discomfort not due to a serious medical condition.

Getting started – it's easy!

Everything you need to know about how to use this program can be found on our orientation website at **Cigna.com/predisability**.

For any additional questions about Healthy Working Life services please contact your account manager.

How to make a referral for pre-disability vocational services

STEP 1:

- When a Human Resources representative, your health clinic staff (if you have them) or the employee's manager identifies someone that appears to be a candidate for pre-disability vocational services, first talk with the employee about what you have noticed.
- Tell the employee that Cigna may be able to help, and ask if the employee would like to be referred to a Vocational Coach for assistance.
- Offer interested employees our customer FAQ flyer which explains in simple terms what a Vocational Coach does and how they can help.

STEP 2:

- Use the referral form located on the orientation website to make the referral and provide some basic information about the employee to the Vocational Coach.
- Have the employee sign a "Cigna Release of Information Authorization" (located on the orientation website). We must have the employee's authorization to begin working with him or her.
- Return the completed referral form and authorization form to Cigna by email to: **PreDisability@Cigna.com** or fax it to: **860.731.3049**.

STEP 3:

- Once the referral is received, a Vocational Coach will confirm receipt of the referral with you. The Coach will contact the employee directly to complete the initial assessment.
- When you make the referral, reassure the employee that he or she will be contacted by the Vocational Coach to set up an appointment and discuss their situation privately. We'll do the rest.

WILL PREPARATION

Plan for your family's future and financial well-being.

Sixty-four percent of Americans do not have a will.* That means that they have little or no control over decisions after they die. It also leaves a burden on family members. They must make hard choices at an emotional time. Advance planning helps to make the process easier. And Cigna's Will Center can help you with the planning process.

Getting started is easy

Go to **CignaWillCenter.com**. It's easy to use and available to you and your spouse anytime day or night. Once you're registered on the site, you can:

- **Get resources and tools to help you plan** and learn more about:
  - Will preparation
  - Estate planning
  - Funeral planning
- Create a central location to store important information for easy access
- **Create state-specific, legal documents online**, including:
  - Last will and testament
  - Living will
  - Financial power of attorney
  - Power of attorney for health care
  - Medical treatment authorization for minors
- **Manage your legal documents**. You can:
  - Preview
  - Edit
  - Download
  - Print

Service representatives are available to help you at **1.800.901.7534****

Visit CignaWillCenter.com today.

For help, call **800.901.7534**.**

Representatives are available between 7:00 AM and 7:00 PM (CST). Or you can email a help request to **Service@ARAGdirect.com**.

* "Perspectives on Wills," conducted by ARAG, April 2013
** No legal advice is provided

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Registrations and customized documents are maintained for two years, which allows individuals to easily make revisions to their legal documents as their personal situation changes.

Will preparation services are independently administered by ARAG®. Cigna does not provide legal services and makes no representations or warranties as to the quality of the information on the ARAG website or the services of ARAG.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Life Insurance Company of North America, Cigna Life Insurance Company of New York, and Connecticut General Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

PROVIDING PEACE OF MIND DURING A TIME OF NEED

Cignassurance Program for beneficiaries

If the unexpected happens, the Cignassurance® Program can help. Available with Cigna Life and Accidental Death and Dismemberment[1] plans, this program provides financial, bereavement and legal support for your loved ones during their time of need. As a beneficiary of your Life and/or Accident plan, they'll get:

- Free and confidential bereavement services over the phone, with licensed clinicians and nurses available 24/7.
- Two free face-to-face counseling sessions with a local Cigna Behavioral Health network therapist.[2]
- 30 minutes of free legal advice with a licensed practicing attorney over the phone.[2] And referrals to discounted, professional legal services for help with estate planning, preparing a will or general advice.[3]
- 30 minutes of free financial services advice from a qualified financial professional over the phone.[2] Additional referrals to financial professionals who can assist with other financial needs.
- Access to a Cignassurance account – a free, interest-bearing account for proceeds over $5,000. This account keeps their insurance proceeds in a safe place and gives them time to deal with more pressing issues. Account balances and activity can be managed 24/7 at Cignassurance.com.
- Our ***Looking Ahead*** guidebook to help your loved ones navigate legal and financial responsibilities and research additional benefits.

Together, all the way.®

Cigna®

1. The Cignassurance Program for beneficiaries is available to beneficiaries receiving coverage checks over $5,000 from Cigna Group Life and Personal Accidental Death and Dismemberment Programs. Cignassurance accounts are not deposit account programs and are not insured by the Federal Deposit Insurance Corporation or any other federal agency. Account balances are the liability of the insurance company and the insurance company reserves the right to reduce account balances for any payment made in error.
2. Phone and face-to-face counseling sessions must be used within one year of the date the claim is approved. Counseling, legal or financial assistance programs are not available under policies insured by Cigna Life Insurance Company of New York.
3. Additional charges may apply.

Financial, bereavement and legal services are independently administered by CLC Incorporated (CLC). Cigna does not provide financial/legal services and makes no representations or warranties as to the quality of the information on the CLC website or the services of CLC.

CIGNA IDENTITY THEFT PROGRAM

Your identity cannot be replicated, but it can be stolen.

Identity Theft occurs when someone uses your personal identifying information, like your name, Social Security number, or credit card number, without your permission, to commit fraud or other crimes. It's America's fastest growing crime, victimizing about 12.7 million people in 2014.* Cigna's Identity Theft program is available to help if this serious crime impacts you.

Valuable help before and after identity theft.

Our identity theft program provides tools and guidance to help with prevention, detection and resolution. This includes:

- Education on how to identify and avoid identity theft before it happens
- An identity theft protection kit that provides the right documents to use and steps to follow if your identity has been compromised
- Help to complete an identity theft affidavit and cancel lost credit cards
- Guidance to help you replace credit cards, a driver's license, Social Security card, passport, etc.
- Assistance with understanding your credit reports to determine if identity theft has occurred, and help with reporting an identity theft to credit reporting agencies
- Help with emergencies while traveling, including translation services with local authorities, filing a police report, and emergency message relay
- Up to $500 cash advance if your wallet or purse is stolen when traveling more than 100 miles from home**

Not sure how to get started?

If you become a victim of identity theft, Cigna's program is here for you.

- Get assistance with credit card fraud, and financial or medical identity theft
- Receive real-time, one-on-one assistance — 24 hours a day, 365 days a year – no matter where you are in the world***
- You'll have unlimited access to our personal case managers until your problem is resolved

If you suspect you might be a victim of identity theft, call 1.888.226.4567 (U.S. and Canada) or 202.331.7635. Personal case managers are standing by to help you. Please indicate that you are a member of the Cigna identity theft program and group #57.

* Javelin Strategy and Research, March, 2014.
** When the theft occurs 100 miles or more from primary residence. Must be secured by a valid credit card and repaid by customer within 30 days, or fees/charges will apply.
*** Assistance with U.S. bank accounts only.

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Offered by: Connecticut General Life Insurance Company, Life Insurance Company of North America or Cigna Life Insurance Company of New York.

Cigna Identity Theft Program services are provided under a contract with Europ Assistance USA. Presented here are highlights of the identity theft program. Full terms, conditions and exclusions are contained in applicable service agreement. **This program is NOT insurance and does not provide for reimbursement of financial losses.**

Not Sure Where to Turn?

We help people solve everyday problems—every day.

Trusted Solutions to Life's Challenges

From online information to confidential consultations with licensed behavioral health professionals, you and your eligible household members have access to a wealth of practical, solution-focused resources to help you reduce stress, strengthen relationships, increase productivity and improve the overall quality of your life.

So Much to Do, So Little Time

Life moves fast. These days it seems like everyone is asked to do more in less time and with less help. With all you have to do, it can be hard to focus on everyday matters, let alone issues that are harder to control, such as:

- Changes in your financial situation
- Family or relationship problems
- Overwork or conflicts at work
- Feeling depressed or anxious
- Quitting tobacco, alcohol or drug use
- Caring for children or aging parents
- Losing weight and living healthier

Challenges like these can make life hard. When you're busy, you might not think there's time to find solutions. So, it's important to know that your organization offers a program that can help you solve everyday—and not so everyday—problems confidentially, 24 hours a day, seven days a week.

There's no cost to you and your eligible household members to use this program; however, any costs or copayments beyond this program will be your responsibility.

Easy Access to Services

Your program is here to provide you and your eligible household members with the right help at the right time. You can quickly get help in a way that works best for you:

- **By Phone**—Call to get consultation and solutions to everyday problems as well as help in a crisis. You will get access to resources or a referral to a professional in your community for confidential help.
- **Online**—Log on to locate counselors in your area. Find targeted information and resources that address your everyday concerns as well as more serious issues. Interactive tools help you discover ways to live a healthy lifestyle.

Frequently Asked Questions

Is there a cost for using my Magellan program?

No. Your Magellan program is a prepaid service offered by your employer or organization.

How many counseling sessions do I have?

Your program includes up to 8 counseling sessions.

Who can use the services offered through my Magellan program?

Services are available to you and, depending on your program, to your eligible dependents or your household members.

What if my counselor and I decide I need additional help?

If you need assistance beyond the scope of what your Magellan program provides, you may be referred to other resources such as your health benefits or community resources.

MAGELLAN
BEHAVIORAL HEALTH

MagellanHealth.com/member

Your program also includes:

Magellan Healthyroads® with PHA

Imagine yourself fit, strong and full of energy!
Your road to good health starts by taking an online Personal Health Assessment. While online, check out Magellan Healthyroads' interactive wellness tools that make getting healthier empowering—and fun, too!

Legal & Financial Consultation Services

Talk to an expert, quickly and confidentially.
Get legal help with family and divorce law, estate planning, and civil or criminal law, among other issues. Financial experts can help with a range of topics, including planning for retirement, debt consolidation and more.

Work-Life Services

Saving you time and money.
Experts provide information and pre-screened referrals for prenatal care, adoption, child care, education, retirement, senior care, special needs and more. An exclusive member discount center offers more than 3.5 million discounts.

Employee Assistance Program

For Professional Consultation

Call 1-800-523-5668

For TTY Users: 1-800-456-4006

Additional information for California residents—Your services are delivered by a Magellan subsidiary: Magellan Health Services of California—Employer Services and Human Affairs International of California. IMPORTANT: Can you read this? If not, we can have somebody help you read it. For free help, please call your toll-free number. IMPORTANTE: ¿Puede leer esta carta? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta carta escrita en Español. Para obtener ayuda gratuita, llame a su número gratituo.

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Flexible Spending Accounts

American Fidelity Assurance Company

Flexible Spending Accounts are a great cost savings tool to help with common medical expenses not covered by your major medical insurance and/or dependent daycare expenses. You can elect a portion of your pay to be deducted, on a pre-tax basis, from each paycheck to use for reimbursements of qualified out-of-pocket expenses throughout the plan year.

Flexible Spending Account Savings Example

With FSA		Without FSA
$30,000	Annual Gross Income	$30,000
- $2,400	Health FSA Deposit	$0
- $2,500	Dependent Care Account Deposit	$0
$25,100	Taxable Gross Income	$30,000
- $5,020	Estimated Federal Tax (20%)	- 6,000
- $1,920.15	Estimated FICA (7.65%)	- 2,295
$18,159.85	Annual Net Income	$21,705
$0	Cost of Medical Expenses	- $2,400
$0	Cost of Dependent DayCare Expenses	- $2,500
$18,159.85	**Spendable Income**	**$16,805**
With an FSA potential annual savings in this example is: $1,354.85		

By using an FSA to pay for eligible expenses, you can cut your taxable income which will result in additional spendable income.

Health Flexible Spending Account (Health FSA)

A Health FSA allows you to allocate money on a pre-tax basis to reimburse yourself for qualified medical expenses for you and your family. Qualified expenses include anything from co-payments, medical deductibles, prescriptions and much more.

Minimum Annual Election: Determined by your employer
Maximum Annual Election: Determined by your employer. Internal Revenue Code allows up to $2600 to be salary reduced per plan year, but your employer will set an amount equal to or less than this amount.

Partial List of Eligible Expenses for Health FSA

Copays/coinsurance

Deductibles

Dental treatments

Diabetic supplies

Prescription drugs and medicines

Eye exams, eyeglasses, contact lenses, contact lens solution and enzyme

Flu shots

Immunizations

Lab fees

Laser/Lasik/RK surgery

Medical exams

Orthodontia

Psychiatric care

Wheelchair

X-rays

For a complete list of eligible expenses, please visit www.americanfidelity.com/FSATips

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Flexible Spending Accounts

Health FSA Card

American Fidelity offers a Health FSA Card to all employees who elect to participate in a Health FSA and who have an employer who allows the card as an option under their Plan. The Health FSA Card gives immediate, convenient access to Health FSA funds at the point of sale for prescriptions, copays, and other common qualified medical expenses. The card may only be used for the Health FSA and is not available for the Dependent Day Care Flexible Spending Account (Dependent Day Care FSA).

Using Your Health FSA Card

Simply swipe your Health FSA Card like you would with any other debit card. Whether at the doctor's office or the dentist, the amount of your expenses will be automatically deducted from your Health FSA. Usually you will need to submit documentation after your swipe, so consider taking a photograph of any receipt (although the receipt alone may not be enough).

Cards for Health FSAs may be used at:

- Healthcare related facilities which include: hospitals, physician offices, dental offices, vision offices; and,
- Merchants participating in the Inventory Information Approval System (IIAS).

There are a few charges that don't require you to provide documentation after your swipe. Remember, even though you are using a card, all Health FSA transactions must be adjudicated with the same information (the date of service, type of service, who the expense was for, and amount of expense) as a manual claim. You can maximize your Health FSA Card experience by using it only for expenses that can be automatically approved. Your Health FSA Card claim will be automatically approved without further documentation requested for:

- Copay Amounts – If your employer provides the necessary information for your medical carrier, the copay amounts can be automatically approved if your copay is stated as a flat dollar amount. If your medical coverage is stated as a coinsurance percentage, additional documentation will be necessary after the swipe to approve the expenses.
- Recurring expenses – You will need to submit documentation after your first swipe and state this will be a recurring claim from the same provider at the same dollar amount. It will be noted on your account that this will be a recurring expense, and additional substantiation will not be required for future swipes for that plan year.
- Items purchased at merchants participating in the IIAS. Please note that not all service providers or retailers who provide medical services or goods participate in the IIAS. For a list of IIAS merchants, you may visit www.sig-is.org.

Activating Your Card

You will receive your card at your home address and may begin using your card on the first day of your plan year. Your card will be automatically activated when you use it for the first time for an eligible expense.

Guidelines for Your Health FSA Card

- **Keep your receipts and related EOBs.** Swipes not automatically approved will require you to submit additional documentation manually. While the transaction may be approved because you have a Health FSA, the expense will need to be verified as an eligible expense by providing the information showing the type of service, the service was incurred during the current plan year and was for the participant or an eligible dependent.
- If a provider does not accept the Health FSA Card, you can request reimbursement after payment by completing the Health FSA Expense Reimbursement Voucher and submitting the voucher with the required documentation. Health FSA reimbursement vouchers can be found online. You can complete the Health FSA Expense Reimbursement Voucher and all required documentation online at www.americanfidelity.com/MyAccount or with our mobile app, AFmobile™. You can also mail/fax these documents to us.
- If you cannot provide the documentation requested, the expense will be deemed ineligible and funds for that claim must be reimbursed back to the Health FSA for that plan year. Acceptable documentation includes: (1) a professional bill or receipt that includes the provider of service, type of service rendered, charges for the service, patient information, and original date of service; (2) insurance company explanation of benefits; (3) pharmacy statement that includes Prescription number, name of prescription and patient information.

Flexible Spending Accounts

American Fidelity Assurance Company

Dependent Day Care Flexible Spending Account (Dependent Day Care FSA)

A Dependent Day Care FSA allows you to allocate money on a pre-tax basis to reimburse yourself for dependent care expenses that allow you (and your spouse) to work such as after school care and daycare centers. Reimbursement is permitted only after the services have been provided and the expense has been paid. As Dependent Day Care FSA contributions are withheld from your paycheck and placed into the account, these funds become available for reimbursement requests. Submit the entire amount of your dependent care expense after the care is provided, even if it exceeds your monthly contribution amount, to maximize reimbursement opportunities. This allows you to build up a "pool" of submitted expenses, with pending amounts ready for reimbursement as soon as your next contribution is received and deposited into your account.

Minimum Annual Election: Determined by your employer.
Maximum Annual Election: While the IRS allows a maximum of $5,000 per year, the employer may set the maximum equal to or lower than this amount.

Common Examples of Eligible Dependent Day Care FSA Expenses
After-school care or extended day programs
Nanny expenses
Baby-sitter inside or outside participant's household
Custodial or elder care expenses if the qualifying individual still spends at least 8 hours each day in the employee's household
Dependent Day Care center* expenses/pre-kindergarten/nursery school expense
Expenses paid to a non-dependent relative of participant to care for the child
Summer day camp if the primary purpose of the expense is custodial in nature and not educational
For a complete list of eligible expenses, please visit www.americanfidelity.com.

**A Dependent Care Center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, regardless of whether the center is run for profit.*

Regardless of whether you participate in the Dependent Day Care FSA under the Section 125 Plan or claim the Dependent Care credit on your income tax return, you must provide the Internal Revenue Service with the name, address and taxpayer identification number (TIN) or Social Security number of your dependent care provider(s) by completing either Schedule 2 of Form 1040A or Form 2441 and attaching it to your annual income tax return. Be sure that you follow the current instructions given by the Internal Revenue Code for preparing your annual income tax return. Failure to provide this information to the IRS could result in loss of the pre-tax treatment of your Dependent Day Care FSA contributions or loss of the Dependent Care Tax Credit.

FSA Fund Availability

Health FSA

Your full annual election is available to you on the first day of the plan year.

Dependent Day Care FSA

Unlike the Health FSA, the entire elected amount is not available on the first day of the plan year, but rather as contributions are received.

Important FSA Notes:

- Participants are allowed a 90-day run-off period after the plan year ends in which to submit claims for expenses that occurred during the plan year but were not yet submitted.
- If you are a new employee entering the FSA Plan during a plan year, reimbursement is only available for services provided after you begin your participation in the FSA Plan.
- If you are enrolled in the Health FSA and take a leave of absence during the plan year, you may:
  1. Prepay the contributions on a pre-tax basis, or
  2. Continue the contributions by remitting them to your employer. Pre-tax contributions may continue if you contiune to receive enough pay, or
  3. Prorate the unpaid contributions over the remaining pay periods when you return to work.
- Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.
- Health FSAs must comply with COBRA and offer COBRA continuation rights to qualified beneficiaries who lose Health FSA coverage as a result of termination of employment sometimes. COBRA may only be offered upon termination of employment if you have a balance remaining in your Health FSA. The balance is calculated by subtracting the reimbursements made from the annual election. If eligible, you may choose to continue your contributions by either sending your contributions to your employer on an after-tax basis each pay period, or, you may choose to pre-tax the remaining contributions for the plan year from your final pay or severance pay. Expenses incurred while contributions are being made are eligible for reimbursement. Sometimes, coverage may not continue beyond the current plan year. If you do not elect to continue the contributions on an after-tax basis, only expenses incurred during the period of employment are reimbursable. Coverage under the Health FSA ceases when the contributions cease.

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Flexible Spending Accounts

Filing a Claim

American Fidelity gives you the convenience of submitting your claim in various ways!

1. Download AFmobile™ from the App Store℠ or from the Google Play™ store to submit claims while on-the-go.

2. Use our secured Online Service Center to submit claims at www.americanfidelity.com/MyAccount.

3. Mail the completed Expense Reimbursement Voucher (for Health FSA) or Dependent Day Care Provider Acknowledgment Form (for Dependent day Care FSA) and documentation to the address located on the bottom of the voucher.

4. Fax your completed Expense Reimbursement Voucher and documentation toll-free to 888-243-2638 or 800-543-3539.

The Dependent Day Care expense reimbursement will be for the qualified expenses provided limited to the amount you have in your account. If the Dependent Day Care qualified expense claim is in excess of your account balance, the balance of the claim will be paid to you as additional contributions are received.

Direct Deposit

By selecting to have your reimbursements deposited directly into to your bank account you can get your reimbursements faster without having to wait for the check to arrive in the mail. Each time a reimbursement is deposited into your bank account, you will be mailed an Explanation of Benefits that shows the deposit as well as a summary of your account.

Accessing Your FSA

By visiting American Fidelity's web site **www.americanfidelity.com** you will have a wealth of information available to you without the use of any customer IDs or passwords. Through the public site you have access to:

- Claim forms
- FSA Reimbursement Forms
- Customer FAQs
- Contact information

Secure Account Management Tools

American Fidelity's Online Service Center is a convenient, secure web site that gives you access to information regarding your American Fidelity account. Available any time of day from home, work or any computer with Internet access, the Online Service Center provides valuable options.

- Check claim status
- Review detailed insurance policy information
- Access FSA information and balances
- Submit address changes
- Submit reimbursement claims or documentation for Health FSA cards

American Fidelity's Customer Engagement Team

American Fidelity believes in making it easy for you. This is why we provide one number for all your customer service needs. You can call into our Customer Engagement Team, to speak with a live representative, for claim questions or status, policy inquiries, questions about your FSA account, and much more. Our customer service representatives stand by ready to assist you with any questions or needs you may have. Simply call 800-662-1113.

Individual Term Life Insurance

American Fidelity Assurance Company

Life insurance is an important factor to any family. It serves as a foundation to help in the case of a loved one's premature death. Plan today to make the right move for your loved ones.

American Fidelity offers an Individual Term Life Insurance policy to help with your financial needs for your short-term and long-term goals.

How the Plan Works

Individual Term Life Insurance has a death benefit with no cash accumulation feature. The policy is initially written for a 10, 20 or 30-year term period, but may be renewed at the insured's option for the same level renewal period depending upon the term chosen.

The last level renewal period is no later than age 70 for the 10-year term policy and age 60 for the 20-year term policy. Thereafter, premiums are renewable annually up to age 90. The 30-year term policy is renewable annually after the initial 30-year term period up to age 90. Renewal rates will be based on the insured's age at the time of renewal.

Optional Riders

Enhance your base plan with the following riders:

- **Spouse Term Rider**
- **Children's Term Rider**

Coverage Feature	What It Means To You
Three Plan Options: 10, 20 and 30-Year Level Term Coverage	Choose the coverage period to meet your financial needs.
Guaranteed Premium	Your premiums are guaranteed during the initial term period you choose.
Guaranteed Death Benefit	Your death benefit is guaranteed during the initial term period you choose.
Accelerated Death Benefit	Receive a portion of the chosen death benefit if you are diagnosed with a covered terminal condition. Limitations and exclusions may apply.
Conversion Benefit	Turn your policy into a permanent plan any time up to age 75. The rate for your new plan will be based on your attained age.
Guaranteed Renewable	Renew your policy up to age 90 regardless of your health.
Interim Coverage	You will be covered from the date of your application if you are insurable for the requested coverage on the date the policy takes effect. This Interim Coverage will remain in force until the policy has been issued or declined.
Enhance Your Coverage	Add an optional Spouse Term or Children's Term Rider to expand your policy.
Easy Application	No medical exams and minimal health questions.[1]
Portable	You own the policy. Take the coverage with you if you choose to leave your current job.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

[1] *Issuance of the policy may depend on the answer to these questions.*

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details, Policy Form Series RCTL05. **Individual life plans do not qualify under Section 125**.

SB-23289-0317

Permanent, Portable, Individual Life Insurance.

Did You Know?

More Americans rely on employer-sponsored life insurance coverage than individual coverage.[1] Your employer may provide you with Group Life Insurance — but, do you have permanent, portable, individual life insurance you can take with you after your employment ends? Life insurance at retirement can be very costly.

Consider a PureLife Plus[2] Policy!

Secure your life insurance premium today at a younger issue age with a permanent and portable product.

- Permanent life insurance to age 121.
- Minimal cash value - premiums dedicated primarily to the purchase of life insurance.
- Long premium guarantees.[3]
- Limited right to partial refund of premium if future premium required to continue coverage increases.[4] (Conditions apply)
- Portable when you leave employment as long as necessary premiums are paid when due.
- Coverage available for employee, spouse/domestic partners, child(ren) and grandchild(ren).[5]

See your American Fidelity Representative today to learn how you can secure a portable policy today!

Express Issue Underwriting Questions:

During the last six months, has the proposed insured:

- Been actively at work on a full time basis, performing usual duties?
- Been absent from work due to illness or medical treatment for a period of more than five (5) consecutive working days?
- Been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormone therapy for cancer, radiation therapy, dialysis treatment, or treatment for alcohol or drug abuse?

That's It – Simple and Easy!

Underwritten by

TEXASLIFE INSURANCE COMPANY

900 Washington Ave. • Waco, Texas 76701
800-283-9233 • www.texaslife.com

Marketed by

AMERICAN FIDELITY
a different opinion

15M055-C 1055 (expires 03/17)
Policy Form: PRFNG-NI-10
PureLife-plus is not available in NJ, NY or PA

SB-25993-0616

[1] LIMRA: Employers Pessimistic About Benefit Costs Under PPACA February 12 2013. [2] Life insurance is not available for purchase under the Section 125 plan. [3] Guarantees are subject to product terms, exclusions and limitations and the insurer's claims-paying ability and financial strength. [4] After the Guaranteed Period, premiums can be lower, the same or higher than the Table Premium. [5] Coverage not available in WA on children and grandchildren. Texas Life complies with all state laws regarding marriages, domestic and civil union partnerships, and legally recognized familial relationships.

Like most life insurance policies, Texas Life policies contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods and terms for keeping them in force. Please contact a Texas Life representative for costs and complete details.

Accident Only Insurance

Limited Benefit Accident Only Insurance

American Fidelity Assurance Company

Whether a weekend warrior with an active lifestyle or just a busy family, accidents can happen anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

American Fidelity's Accident Only Insurance policy provides you a solution for those unforeseen accidents that life sometimes delivers. Our Limited Benefit Accident Only Insurance is designed to help pay for the unexpected medical expenses an individual may incur for the treatment of covered injuries received in an accident.

How the Plan Works

Our Accident Only Insurance policy pays according to a wide-ranging schedule of benefits. In addition, the policy provides 24-hour coverage for accidents that occur both on and off the job.

All benefits are only paid as a result of Injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. All benefits are paid once per Covered Person per Covered Accident unless otherwise specified in the Limitations and Exclusions section.

Optional Rider

Enhance your base plan with the following rider:

- **Accident Benefit Enhancement Rider**

Coverage Feature	What It Means For You
Plan Options: Basic, Enhanced, and Enhanced Plus	Choose the plan to meet your financial needs.
Four Choices of Coverage: Individual, Individual and Spouse, Individual and Child, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers all types of covered injuries.
Wellness Benefit	The plan pays an annual Wellness Benefit for one Covered Person to receive a routine physicial exam, including immunizations and preventative testing.
Accident Emergency Treatment Benefit	Receive a benefit when emergency treatment in a Physician's office or emergency room occurs within 72 hours of a covered accident.
Benefit Paid Directly to You, to use as you see fit	Use the benefit however best fits your financial needs.
Guaranteed Renewable	Keep your coverage as long as premiums are paid as required.
24-Hour Coverage	You are covered on or off the job.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Refer to your policy for complete details, AO-03 series with AMDI258 rider. **This product is inappropriate for people who are eligible for Medicaid coverage.** The premium and amount of benefits provided vary dependent upon the plan selected. The company has the right to change premiums by class. Availability of riders my vary by state.

SB-23288-0317

Cancer Insurance

Limited Benefit Cancer Insurance Policy

American Fidelity Assurance Company

A cancer diagnosis may be overwhelming. Even with a good medical plan, the out-of-pocket costs of cancer treatment, such as travel, childcare, and loss of income, are considerable and may not be covered.

American Fidelity Assurance Company's Cancer Insurance offers a solution to help you focus your attention on fighting cancer. We offer plans that can help assist with out-of-pocket costs often associated with a cancer diagnosis.

How the Plan Works

Our plan is designed to help cover expenses if you are diagnosed with a covered Cancer. With over 20 benefits available to you, this plan provides benefits for the treatment of cancer, transportation, hospitalization and more. We provide the benefit directly to you, to be used however you see fit.

Optional Riders

Enhance your base plan with the following riders:

- **Critical Illness Rider**
  Includes a cancer benefit and a heart attack/stroke benefit
- **Hospital Intensive Care Unit Rider**

Coverage Feature	What It Means For You
Plan Options: Basic, Enhanced and Enhanced Plus	Choose the plan to meet your financial needs.
Three Choices of Coverage: Individual, Single Parent Family, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers a wide range of treatments.
Benefit Paid Directly to You	Use the money however best fits your financial needs.
Guaranteed Renewable	Policy is guaranteed renewable as long as premiums are paid as required.
Diagnostic and Prevention Benefit	Receive a benefit for visiting your doctor for a cancer screening test, which helps with early detection.
Transportation and Lodging	Receive benefits if you travel more than 50 miles from your home using the most direct route for covered treatment.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by choosing from a selection of optional riders.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage**. The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected.

SB-23287-0317

Group Critical Illness Insurance*,+,##

Limited Benefit Group Critical Illness

Surviving a Critical Illness may come at a high price.

Why You Need Critical Illness Insurance

Surviving a critical illness, such as a heart attack or stroke, may come at a high price. Although many medical plans provide coverage for costs arising from a critical illness, there are still various out-of-pocket expenses that can affect anyone's finances. Copayments, transportation, everyday expenditures, and lost income can add up quickly.

Group Limited Benefit Critical Illness Insurance from American Fidelity Assurance Company can assist with the expenses that may not be covered by traditional medical insurance. The plan is designed to pay a lump sum benefit amount to help cover expenses if you are diagnosed with a covered critical illness.

How It Helps

- **Various Coverage Options**
  Choose the coverage amount that best suits your needs – a lump sum benefit of $10,000, $20,000, or $30,000.
- **Benefit Payments Made Directly to You**
  Your benefit payments may be deposited directly into your bank account, to be used for any expense you wish.
- **Health Screening Benefit**
  Receive a benefit for your covered health screening test. This benefit features eight qualified tests, including a stress test, echo cardiogram, electrocardiogram (EKG), blood glucose testing, and more.

Every 40 seconds, someone in the United States has a stroke.[1]

[1]*American Heart Association: Heart Disease and Stroke Statistics 2015 Update, p.e180. January 2015.*

Help protect yourself from the expenses associated with a critical illness. American Fidelity's Limited Benefit Critical Illness Insurance can help.

** Limitations, exclusions, and waiting periods may apply.*
+ **This product is inappropriate for people who are eligible for Medicaid Coverage.**
This product is only offered on an after tax basis.

Visit with your American Fidelity account manager to learn more.

[Rep Name, Lic #
Title
Alabama Branch Office
2111 Parkway Office Circle, Ste 250
Birmingham, AL 35244
800-365-3714 • 205-987-0950]
americanfidelity.com

AMERICAN FIDELITY
a different opinion™

SB-24724-0617

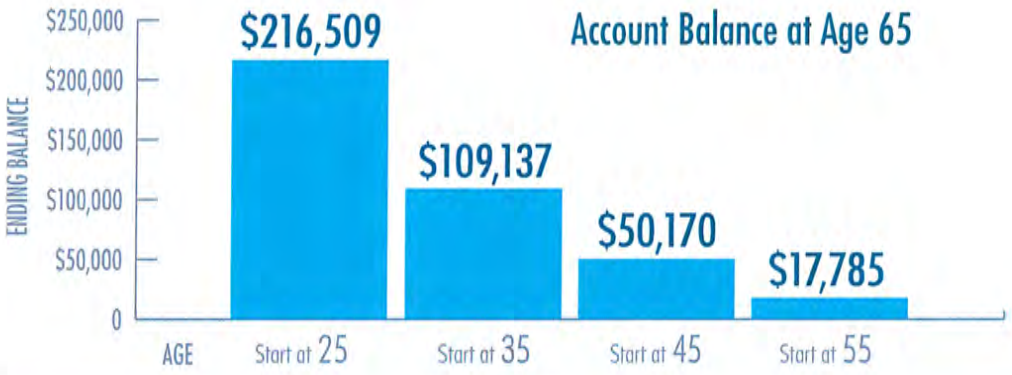
WHY SAVE NOW?

Saving to your 457 deferred compensation plan has two key advantages:

1 **Convenient contributions** — made directly from your paycheck.

2 **Tax benefits** — pre-tax contributions reduce your current taxable income, and all taxes, including on earnings, are deferred until you withdraw.

Saving early matters



For illustrative purposes only. Actual returns may be higher or lower. Assumes $50 bi-weekly contributions and effective 6% average annual return, compounded biweekly.

- See how delaying saving can cost you — www.icmarc.org/costofdelay
- Guided Pathways® helps you decide how much to save and how to invest — www.icmarc.org/guidedpathways

Your ICMA-RC representative can help.

Joanne Holan
jholan@icmarc.org
877-313-8317

AC: 27527-0616-8380

ICMA RC
BUILDING PUBLIC SECTOR RETIREMENT SECURITY

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TEL: 202-962-4600 | FAX: 202-962-4601 | TOLL FREE: 800-669-7400 | WWW.ICMARC.ORG

GET TO KNOW YOUR 457 PLAN

Your pension and Social Security may go far, but you will likely need more income for a truly comfortable future. That's where your 457 deferred compensation plan comes in — see why it matters to you!

1 It's easy to contribute

- Make automatic paycheck contributions.
- Change your contributions any time.

2 Get tax benefits along the way

- Pre-tax contributions lower your tax bill, lessening the impact to your take-home pay.
- Delay all taxes, until you take money out.

3 A wide range of investments are available

- You control investment decisions, choosing from available options.
- Consider a diversified target-date fund or build your own portfolio. Get help with Guided Pathways® — www.icmarc.org/guidedpathways.

4 Take out what you need

- You control withdrawals upon separation from service with your employer.*
- Only 457 plans have no early withdrawal penalty regardless of your age.**

* *Depending on your plan's rules, withdrawal and loan options may be available while you're still working.*

** *The penalty may apply to non-457 plan assets rolled into a 457 plan and subsequently withdrawn prior to age 59½.*

HOW MUCH CAN I CONTRIBUTE?

For 2017, you can save as much as:

- $18,000
- $24,000 if age 50 or over
- $36,000 if you qualify for pre-retirement catch-up contributions.

Reminder: you may be able to contribute accrued sick or vacation leave.

Can't save that much? Even small savings can really add up — start with as little as $10 per paycheck.

The sooner you save, the more your money can grow — see how at www.icmarc.org/costofdelay.

Already enrolled? Aim to save more — see how at www.icmarc.org/savingsboost.

GET HELP ONLINE

- Manage your account — www.icmarc.org/login
- Tips and tools to help you save, invest, and retire — www.icmarc.org/education

Your ICMA-RC representative can help.

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ICMA-RC
Building Retirement Security

Meet Your ICMA-RC Representatives

What questions do you have about your retirement accounts and financial goals?

Meet with your ICMA-RC representatives to help you plan, save, and invest.

Joanne Holan, your Retirement Plans Specialist, is your primary contact for retirement account questions, including enrollments, contributions, investments, and distributions.

James Collins, your CERTIFIED FINANCIAL PLANNER™, is available for broader and more complex discussions about your overall finances, including topics that impact your retirement security, such as credit and debt, insurance and estate planning, college funding, and tax and health care costs.

Reach out to Joanne and James:

Joanne Holan
Retirement Plans Specialist
877-313-8317
jholan@icmarc.org

James Collins
CERTIFIED FINANCIAL PLANNER™
866-731-1051
jcollins@icmarc.org

ICMA-RC has a variety of tips, tools, and services to help you manage your retirement accounts – www.icmarc.org/realize.

Since 1972, our sole mission has been to help public sector employees build retirement security. *How can we help you?*

AC: 23712-0215-7635

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Carrier Contact Information

Benefit	Carrier	Phone Number	Website
Medical	CalPERS	(888) 225-7377	www.calpers.ca.gov CalPERS > Active Members > Open Enrollment
Dental	Delta Dental	HMO: (800) 422-4234 PPO: (800) 765-6003	www.deltadentalins.com
Vision	Vision Service Plan	(800) 877-7195	www.vsp.com
Life and AD&D and Disability	Cigna	(800) 362-4462	www.cigna.com
Cigna Health Rewards®	Cigna	(800) 258-3312	www.cigna.com/rewards Password: savings
Identity Theft Services	Cigna	US: (888) 226-4567 Outside US: (202) 331-7635	www.cignaplussavings.com/Support/IdentityTheftProgram
Will Preparation Program	Cigna	(800) 901-7534	www.CIGNAWillCenter.com
Employee Assistance Program	Magellan	(800) 523-5668	www.MagellanHealth.com
Flexible Spending Accounts	American Fidelity	(800) 654-8489, option 2, 3	www.americanfidelity.com
Voluntary Benefits	American Fidelity	(800) 654-8489, option 2, 4	www.americanfidelity.com
457 Deferred Compensation Plan	ICMA	(877) 313-8317	www.icmarc.org

Contact your Town of Los Gatos Human Resources Benefits Team at hr@losgatosca.gov or (408) 399-5739 for more information on any of the benefits outlined in this benefits guide.

While every effort has been made to be as accurate as possible in developing the enclosed information, the official plan documents prevail in all cases. This is not a legal document. It is a brief summary of benefits and is not considered "Evidence of Coverage." Please refer to the policy/plan documents for a complete description of the controlling terms, coverages, exclusions, limitations and conditions of coverage. In case of any discrepancy between this information and the policy/plan documents, the policy/plan documents will prevail.

Town of Los Gatos reserves the right to terminate, suspend, withdraw, or modify the benefits described in the policy/plan documents in whole or in part, at any time. No statement in this or any other document, and no oral representation should be construed as a waiver of this right. This summary is the confidential property of Town of Los Gatos.